					Cen	lincale	of Death		Reg. No.			
	1. Decedent's N	leme (First, Middle, I	Last)			1111		2. Date of		Van	/3. Tir	ne of Death
	Anne	N W	lontie	1 =				Month	T. 28.	2000	6.	MA 00
	4e Fecility Nam	ne (If not institution, g	rive street end num	ber)			4b. City, To	wn, or Location of D		inty of Dea		
	1	109 PARR	ISH DR.				ROCE	VILLE		MONTO	OMERY	
ń	5. Social Securi			7. Age (In yrs.	lest birthday)	If Under 1	rear If Under		Birth Dey, Year)	-		tete or Foreign
	219-21	-0318	1□M 2MF	95	Yrs.	Months I	eys Hours	Min. (Month)	7-04		CARAG	
	Usual Residence								1			
	10a. State	10b. County		10c. Cit	ty, Town or Loc	cation						de City Limits
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	10e. Street and			1		10f. Zip Co	ode		10g. Citizer	of What C	ountry?	
rai	11109	Parris	sh Dr	IVE		20	852		N	ICARA	GUA	
	11. Merital Stat		12. Was Deced		,S. 13. W	Ves Deceden	t of Hispenic Or	gin? (Specify Yes on, Puerto Rican, etc.	No- 14.	Race - Am Bleck, Wh	ancen Indie	en,
	1 Never N	Married 2 Married		2 💢 No		XYes 2		, r sono mosm, ono.			10, 010.	
by by	3 Widow	ed 4 Divorced	Yeer or Dai		1	200 20	1 Specify	ICARAGUAN	30	ecify:	WHITE	
	//	15. Decedent's Specify only highest			16e. Decede	ent's Usuel C	occupation done during mos	t of working	16b. Kind	of Business	s/Industry	
L		Secondary (0-12)	College (1-	4or 5+)	life. D	O NOT use	retired)					
	1	2				HOME	,			OME		
To Be	17. Fether's Ne	me (First, Middle, La	st)				18. Moth	er's Neme (First, Mic		n Sumeme)		
		DIONISIO	M	ONTIEL				EMIL	A	GOMEZ		
	19a. Informant	's Name/Relationship	(Type, Print)		19b. Mailing	g Address (S	Street end Numb	er or Rurel Route No	mber, City or To	wn, Stete,	Zip Code)	
	MAGDA	SOBALVA	RRO/DAUGH	TER	SAM	Æ AS	ITEM	#10				
	20a. Method of				Plece of Dispos			Date	20c. Local	ion - City o	r Town, Sta	ite
		2 Cremation 3 on 5 ☐ Other (Spe		itate			EMATORY	9/30/0	O RIV	ERDAI	E, MI).
	21. Signature o	of Funeral Service Lig	onane.		V 111 14 41/4	1410 OFF					_,	
		or a manufacture and	partition		22.	Name and	Address of Fecili	ty				
	10/	nunk	ver bush	0						TITLE	CDDT	20906
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State Registrar

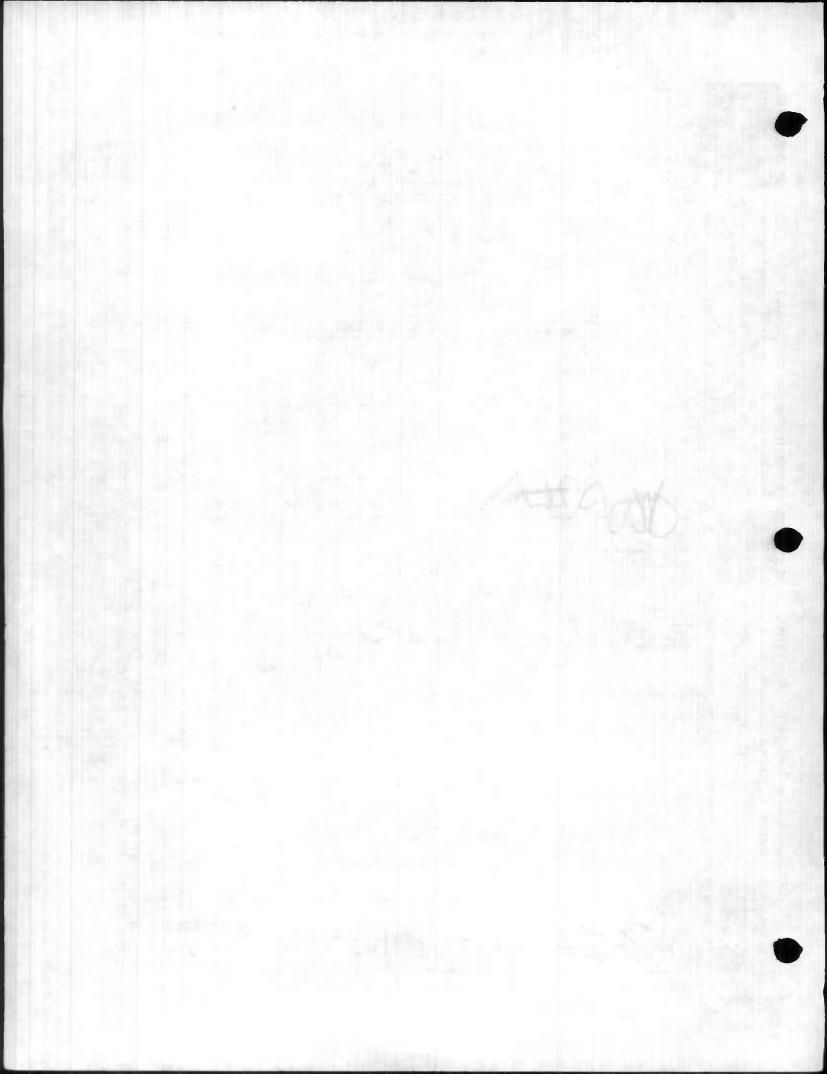
32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

			(Certific	cate of	Death		Reg. No.				
Physician	1. Decedent's Name (First, Middle, L.	ast)					2. Date of De Month	eath Day	Year 3.	. Time of Death		
/Medical	Marie Louise								2000 3	:21 AM		
Examiner	4a Facility Name (If not institution, gi	ve street and number)			4	b. City, Town,	or Location of Deet	h 4c. County	of Deeth			
	SHADY GROVE					ROC	KVILLE Hrs. 8. Date of Bi		TGOME!			
Funeral		Sex 7. Age ((In yrs. last birth	nday) If Ui	nder 1 Year hths Days		Ain. (Month, Di	ey, Year)	9. Birthplace Country)	(Stete or Foreign		
Director	412-34-7480 January 30,							30, 1927	Tennes	ssee		
Lbe notified at	Usuat Residence of Decedent 10e. State 10b. County	1	Oc. City, Town	or Location					10d 1	Inside City Limits		
or thems 23a or 28a-f show unioer must be notified at / Funeral Director									100	1⊠ Yes 2□ No		
or 25s-f s be notified Director	Maryland Montgom	ery	Rockvi					10g. Citizen of What Country?				
Dir.	10e. Street and Number			10f. Zip Code								
2 12	2304 Veirs Mill R			20851					State			
finer must sher must Funeral	11. Maritel Stetus	12. Was Decedent Ev Armed Forces?		13. Was D	ecedent of H specify Cube	li <i>s</i> panic Origini en, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	D- 14. Rac Blac	ce - American Ir ck, White, etc.	ndian,		
by F	1 Never Married 2 Married	1 ☐ Yes 2 ☒ No		1 ☐ Ye	es 2⊠No	Specify:		Specify	V: LThite			
	3₺ Widowed 4 Divorced	Year or Dates:						1	White			
Completed	15. Decedent's E (Specify only highest gi		1	Give kind o	Usual Occup I work done	during most of	working	16b. Kind of B	usiness/Industr	ry		
ם	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)			OT use retired	7)		Vitro	Town own	tion		
		4	Dr	aftsp	erson	40.01.01.01	No. of the state of	Vitro (CIOH		
88	17. Father's Name (First, Middle, Las	1)					Neme (First, Middle Wilshire		10)			
2	David E. Hurst											
	19a. Informant's Name/Retationship						r Rural Route Numb					
	Thomas E. Conkey/	Son in law				oad, No	kesville,	Virgini	la 2018	1		
	20a. Method of Disposition	70	20b. Place of I	Disposition , cremetory	(Neme of or other plea	ce)	September September	20c, Location -	City or Town,	State		
	1 ☐ Buriel 2 ☑ Cremation 3 (4 ☐ Donation 5 ☐ Other (Spec.		Montgome	erv Cre	ematoriu	m. Inc.		Bethesda	a. Marv	land		
	21. Signature of Funeral Service Lib	mage A	11011050112	22. Nam	ne and Addre	ss of Facility I	Robert A.	Pumphre	y Funer	ral Home		
	Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805											
	ROCKVIIIE, Halyland 20030-2003											
-	23. Part 1 Entur he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should be the disease on each line.									proximate erval Between eset end Deeth		
ו	Immediate Cause (Final											
	disease or condition resulting in death)	a. Myocard	ial Inf	arcti	on				Но	urs		
70			ue to (or as a co									
nin.	b. Coronary Artery Disease											
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	De	ue to (or as e co	onsequenca	a of):				130			
	cause. Enter Underlying Cause (Disease or injury	c						1.3				
edicai	that Initiated events resulting in death) Last	Du	e to (or es e co	onsequence	of):							
/Me		d										
an												
Physiciar	Part II. Other significant conditions	contributing to death but	nol resulting in	the underlyi	ing cause giv	ven in Pert I.	23b. Did	l tobacco use co	intributa to the	causa of death		
P.	The State of State of						1□	1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unkno				
by							_		1			
9								s an autopsy ormed?	24b. Were a aveilat	autopsy findings ble prior to		
pie							-		comple of deal	etion of cause th?		
Completed							10	Yes 25 No	1□Y6	es 2 No		
	25. Was case referred to medical					26 Diago of	Death (Check only			20110		
o Be	examiner?	Hospital:	2 C C C C C C		Oth	or:			(6:			
- To	27. Menner of Death	1 🖾 Inpatient	2 ER/Out		DOA 28c. tniur		ng Home 5 ☐ Res 28d, Describe	how injury occur				
Certification:	1 ⊠Natural 5 ☐ Pending	(Month, Day Y	(ear) In	jury	28c. tnjur Wor	rk? Yes 2 □ No		,,				
Ca	3 Suicide 6 Could not	De Dines of Injun	. At home fam				28f Location	(Street end Numi	her or Rurel Re	nute Number		
T	4 ☐ Homicide determined	building, etc.	(Specify)	III, 311 00 1, 1a	iciory, omice			wn, Stete)	701 O1 1101 G1 110	3010 110111001,		
	DO- Codition AFT Codit to B											
edicai	(Check only 2 Medical Exa	hysician: To the best of r miner: On the basis of e	xamination and									
N N	one)	and manner state	d.		00. 11.			0010	101 11 0	M = 1		
-	29b. Signature and atte of certifier	5 L157	5111		29c. Licens)	29d. Date signe		r, rear)		
	1/M pa	5 (1)	Zell		11	330		9.21	.00			
	30. Name and address of person who	completed cause of dea	th (Item 23a) (T	Type, Print)	1454					1.33		
	Frank Listello, N	1.D., 9901 M	ledical	Cente	er Driv	ve, Roc	kville, M	D 20850				
State	31. Date filed (Month, Day, Year)	32 Registrar's	s Signature	_								
gistrar	SEP 2 5 20	100 Den	19	· All	socks	1						

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #8,10/6/2000, BMW, Montg. Co 1. Decedent's Nama (First, Middle, Last) 2. Dala of Death 3. Time of Death Day Year Month **Physician** Eleanor 4b. City, Town, or Location of Death Mitchell. 21 2000 4c. County of Death 8:30 p.m /Medical Pittman 4a Facility Nama (If not institution, give street and number) Examiner Bedford Court Silver Spring Montgomery If Under 1 Year 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 F Yrs. 578-32-6769 **Director** 1902 WV Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or frame 23s or 28s-f show the Medical Examiner must be notified at Director MD 1 ☐ Yes 2 No Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 3700 International 20906 Funeral Drive USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, etc. 11. Marital Status permit. Peges 1 end 2 should be filed within 72 hours after Department of Health and Mentel Hygiene.
Important: If Item 27 is marked other than "natural", or frei any injury or other traumatic avent, the Medical Erannian 1 ☐ Yas 2 ☐ KNo If Yas, Giva Year or Datas: 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ Yes Specify Specify: à 3 □ Vidowad 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Clerical 12 U.S. Government 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 2 Joseph Jay Pittman Lulu Frye 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jay Robinson / nephew 111 Marine Terrace Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 9/23/00 Alexandria, VA Metropolitan Crematory 21. Signatura of Funaral Sarvice Licenses 22. Name and Address of Facility Adams-Green Funeral Home Hans 721 Elden Street Herndon, 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Ceuse (Final /Medical disaasa or condition resulting in death) **Examiner** Examiner The law requires that the death certificate be executed Sequantially list conditions, if eny, leeding to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiated events resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760 Physician/Medicai Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown este Vascula signt 1 be a by Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy sion 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: Be 25. Was casa rafarred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 Metural 1∏Yes 2∏No 2 Accident 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier

State

24

(Check only one)

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29b. Signatura and little of certifiar

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

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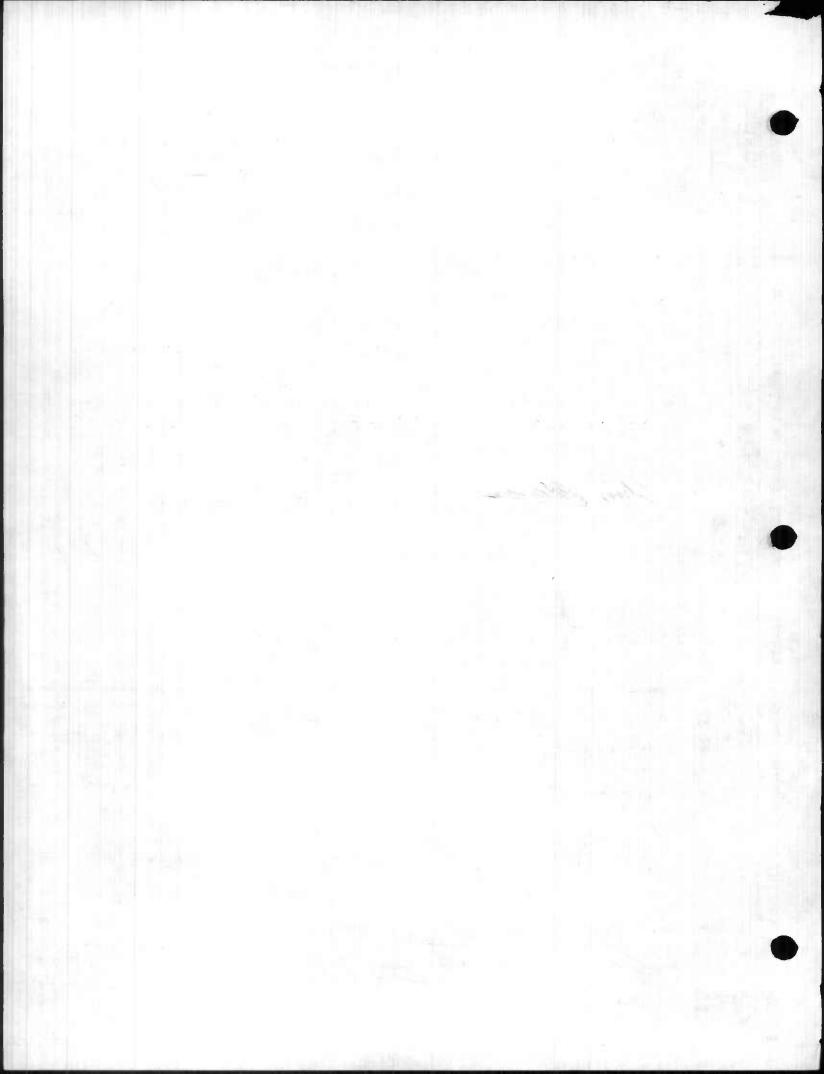
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29c. License number

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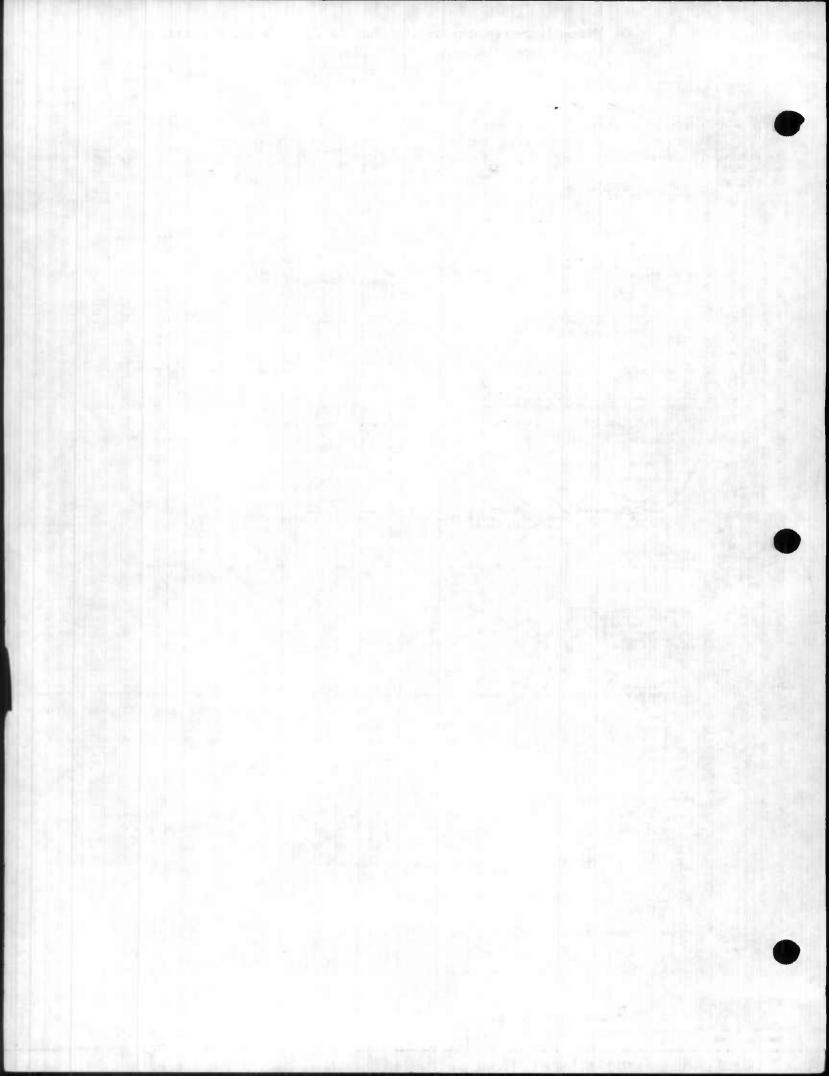
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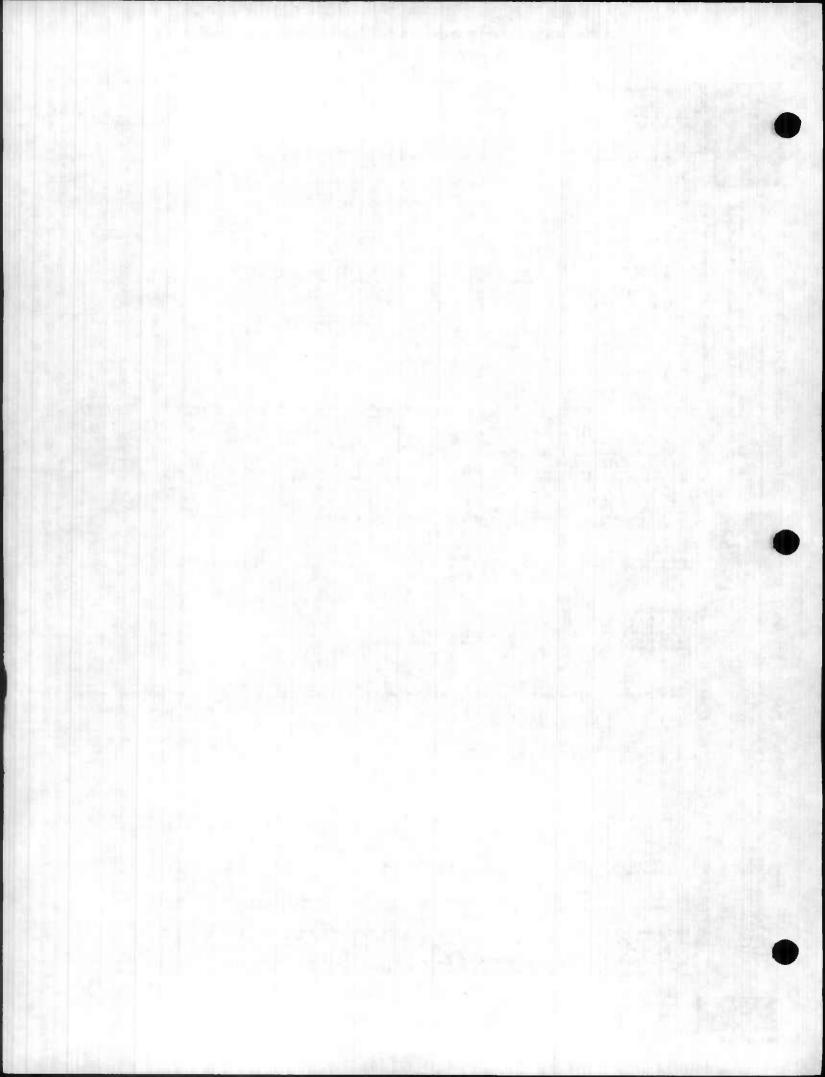
State of Maryland / Department of Health and Mental Hygiene 0 32001

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		lvert	10c. CRy, Tov	or Location		Solo	omons			10	od. Inside City Limits 1 ☐ Yes 2 ₺ No	
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0		Wilbur D. Ro	gers			- 7-		Lenor	e C. Engl	lehardt		
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-	Ann Michnowicz	/ Daughter		P.0	D. Box	1263,	255 C	Street,	Solomons	, MD 20	0688	
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pieted								24a. Wes	en eutopsy rmad?	eve	re eutopsy findings elable prior to appletion of cause daeth?	
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Cermica	2 Accident investigation 3 Suicide 6 Could not be determined 28a. Place of trijury - At home, tarm, street, fectory, office building, etc. (Specify)								ber or Rure	i Route Number,		
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	O. Nama and address of person who	completed cause of d			2			3 1 1 3		Tens	4 20,20	
3	O. Nama and address of person who Joseph Barth, J. Date tiled (Month, Day, Year)	ма			28,			3 1 1 3	yland	206		
CELLICATION: O DE COMOTECEO DY PLYSICION PARINE		Solomo Decedent 10a. Stete 10b. County MD Ca 10e. Street and Number P.O. 11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gring the stem of t	4e Facility Name (if not Institution, give street and number) Solomon Nursing Ce 5. Social Security Number 6. Sex 230-46-1773 1	4e Facility Name* (If not Institution, give street and number) Solomon Nursing Center 5. Social Security Number 230-46-1773 Usuel Residence of Decedent 10a. Stete 10b. County MD Calvert 10c. Street and Number P.O. Box 1263 11. Meritel Stetus 11 Never Merried 2 Merried 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 17. Fether's Nama (First, Middle, Last) Wilbur D. Rogers 19a. Informant's Neme/Relationship (Type, Print) Anth Michnowicz / Daughter 20a. Method of Disposition 18 Burial 2 Ceremetion 3 Removel from State 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licensee Wilbur D. Rogers 19a. Parti. Entar the disease, or complications that caused the deeth. Do service in the disease or condition resulting in deeth) 23a. Parti. Entar the disease, or complications that caused the deeth. Do service in the disease or condition resulting in deeth) 25. Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury their initiated eventia resulting in death) Lest Pert II. Other algnificant conditions contributing to death but not resulting in death) Lest 25. Was casa referred to medicat varminer? 1 Yes 20-40 27. Menner of Death 28a. Data of Injury Al home, to building, etc. (Specify) 28b. Due to (or as e determined) 27c. Menner of Death 28c. Data of Injury Al home, to building, etc. (Specify) 28c. Data of Injury Al home, to building, etc. (Specify)	Solomon Nursing Center Solomon Nursing Cen	Solomon Nursing Center Solomon Cen	46. 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State of Maryland / Department of Health and Mental Hygiene 00 32005

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and 2 ealth a n 27 is		James L.	McKay /	Son		224	Nich	ols M	anor Dr	ive. Ste	vensvill	e. MI	21666
Health em 27 l		20e. Mathod of Dis		DOIL	20	b. Place of D	isposition (Vema of		Data	20c. Location -		
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		23a. Part1. Entar tha disease, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximata Intarval Between	
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F 2 5 C	T	4 🗆 Homicide	Getairrine	buil	ce of Injury - Adding, atc. (Sp	ecity)		,		City or 7	own, Stata)		
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0 1 × 0	-	29b. Signature and	ye or certifier	. 1		0.		29c. Licans	e number		29d. Dafa signe	u (Month	, Day, 1941)
20		- Ju	od. MI	/Su	nel	1		D 35	996		Septemb	er 2:	2, 2000
		30. Nema and address of person who complated ceusa of death (Itam 23a) (Type, Print)											
		Linda M.	Burrell,	MD 2	730 IIn	iversi	tv R1	vd.	West # 4	00. Silv	er_Sprin	o . M	D 20902
	State	31. Data filed (Mor			Registrar's Si	ALL BUT DO A STORY	4	,		UU, DIIV	or obitili	53 111	20702
	Clare		SFP25	2000	Some	w 1			,				



	State of Mary	land / Department of I Certificate of		ygiene 00 32006							
Physiciar /Medica			mber 23, 2000 10:25 pm								
Examine	4a Facility Name (If not Institution, give street and number)		4b. City, Town, or Location of De	ath 4c. County of Death							
	Suburban Hospital 5. Social Security Number 6. Sax 7. Aga (In	yrs. last birthday) If Undar 1 Yaer	Bethesda If Under 24 Hrs. 8 Date of	Montgomery Birth 9 Birthplace (State or Foreign							
Funeral Director	1 LA ONE	34 Yrs. Months Days	Hours Min. (Month,	Birth 9. Birthplaca (Stata or Foraign Country) 27, 1915 DC							
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ygiane.	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occu (Giva kind of work dona lifa. DO NOT usa retire	during most of working	16b. Kind of Business/Industry							
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any l	1 trade vola	Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 209									
	23a. Part1. Entar tha disease, or com/ cutions that caused tha shock, or heart failure. List only one cause on each line.	daath. Do not antar tha mode of dy	ing, such es cardiac or raspiraton	verrast, Approximete Intervel Batween							
Wedical was a second of the attending physician and school for use as the buriel-Iransit	Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disaase or injury that initiated avants rasulting in death) Lest	to (or as a consequence of):	YPA\$S								
for usa a	0										
detached	Part If. Other eignificant conditions confributing to death but no	t resulting in the underlying cause g		Id tobacco use contribute to the cause of death?							
igned by be detac	Coronary artery desease			□ Yes 2 No 3 Probably 4 Unknown							
should should	Hypertension		24a. W	as an autopsy informed? 24b. Wara autopsy findings availabla prior to completion of causa of death?							
ata has b				□ Yas X No 1 □ Yas 2 □ No							
cartificata rector, pag	25. Was case referred to medical		26. Place of Death (Check on	ly ona)							
0.0	axaminar? 1 ☐ Yas 2 No Hospital: 1 Inpatient	2 ER/Outpatient 3 DOA	thar: 4 Nursing Homa 5 R	esidenca 6 Othar (Specity)							
octor: Affar the by the funeral	27. Mannar of Death 1 Natural 5 Pending (Month, Day Yea 2 Accident Invastigation		ury at 28d. Dascril ork?] Yas 2 ☐ No	be how injury occurred							
Partie I	3 ☐ Suicida 6 ☐ Could not be detarmined 28a. Placa of Injury - building, etc. (S)	At homa, farm, street, factory, office pecify)		n (Street and Number or Rural Routa Number, Town, Stata)							
To the Hospital within 24 hours To the Funeral complataly filled	29a. Certifier (Check only one) 1 Certifying Physician: To tha best of my one) 1 Medical Examiner: On the basis of axa end mannar stated.										
To the within To the comple	29b. Signature and title of certifier		se number	29d. Data signed (Month, Day, Year)							
12	touch regulgous	DZ	3019	9124/2000							
	30. Nama and addrass of person who completed causa of death	(ftem 23a) (Type, Print)	E; BETHESDA	MD 20814							
	21 Date filed (Month Day Your) 20 Projected 6		אטכטונויטט ,	דוטטב שיו							
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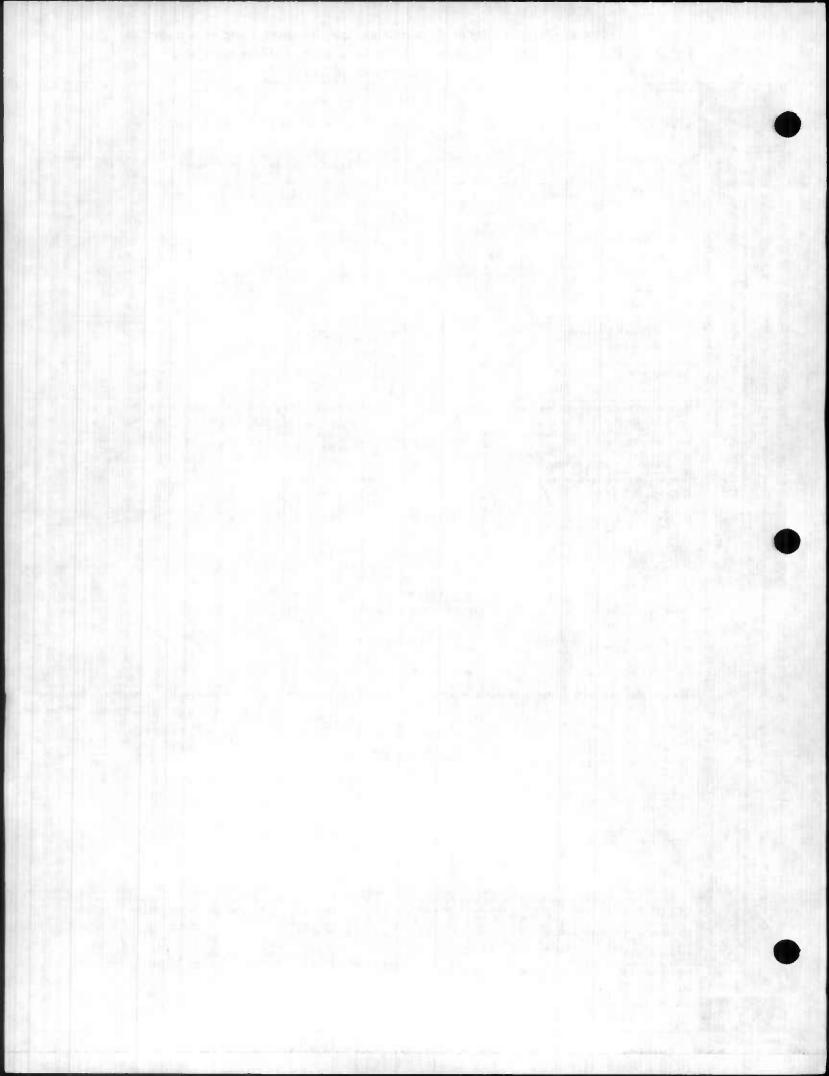
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Data of Death Month Day Year September 24, 2000 9:45pm **Physician** John Patrick McGivern /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1744 Point No Point Dr. Annapolis Anne Arundel If Undar 1 Yaar If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) NOV 1, 19 Birthplace (State or Foreign Country)
 NY 5 Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1 1 M 2 □ F 88 Yrs. 097-05-8950 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No MD Anne Arundel Annapolis Director the Medical Examiner must be notifi-10a. Streat and Number 10f. Zip Code 10g. Citizen of What Country? Nerva 23a or 21401 United States 1744 Point No Point Dr. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14 Race - American Indian Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 6 Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) Communications pormit. Pages 1 and 2 should be field within 7 Department of Health and Mental Hygiere. Important: If Item 27 is marked other than "e any Injury or other treumetic event, the Mag Elementary/Secondary (0-12) College (1-4or 5+) Executive 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) John Aurthor McGivern Rose Abruscate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Berta McGivern /Wife 1744 Point No Point Dr., Annapolis, MD 21401 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sep 27 20c. Location - City or Town, State 2000 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory any Injury DDCs. 22 Name and Address of Facility
Rapp Funeral & Cremation Services
933 Gist Avenue Silver Spring, M Silver Spring, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tallure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical **Examiner** Physician/Medical Examiner The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last use as the burial-tran Due to (or as a consequance of) Box 68760. the attending physician Due to (or as a consequenca of): P.0. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, p after death.

Director: After this certificate has been significate has been significantly the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy pertormed? Be Completed 250 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2√ No 5 Residenca 6 □Other (Specify) Certification: To 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Panding investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \ Homicide To the Hospital within 24 hours a To the Funeral Completaly filled 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 10 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Plauner 11509 Ritchie MD 21012 Victor 31. Data filed (Month, Day, Year) SEP 2 7 32. Registrar's Signatura State

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** September 27, 2000 12:27 pm McCleary Teresa Agnes /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Holy Cross Rehabilitation and Nursing Center Burtonsville Montgomery 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 XF 164-03-8640 1910 Director 90 May 6, England Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahov 7 is marked other than "natural", or flama 23a or 28a-f ahov traumatic event, the Medical Executor sust be noutled as 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Burtonsville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth vibropardment of Health and Mentel Hygiene. Important: If them 27 Is marked other than "natural", or flama 23a any Injury or other traumatic event, the sec USA 20866 Funeral 3305 Bigelow Court 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) John Patrick Davitt Julia Christiana Ormsby 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3305 Bigelow Court, Burtonsville, MD 20866 Robert T. McCleary / Husband 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 19/30/00 Silver Spring, MD 4 ☐ Donation 5 ☐ Othar (Specify) Gate of Heaven Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 coli 23a Part 1. Enter the disease or or implications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart tailure. Let only one cause on each lina. Approximate Interval Batween Onsat and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) a Squamous Cell Carcinoma of Mouth 2 years Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last the burief-trer Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of) USB 85 P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension þ Division of Vital Records, 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performad? Hyperlipidemia this certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 🗓 No or Attending Physician: 25. Was cesa referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: W Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) funeral 27. Mannar of Death 28b. Time of Injury 28d. Describe how injury occurred After 1 28c. Injury at Work? 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident the after death 6 Could not be datamined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital o within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

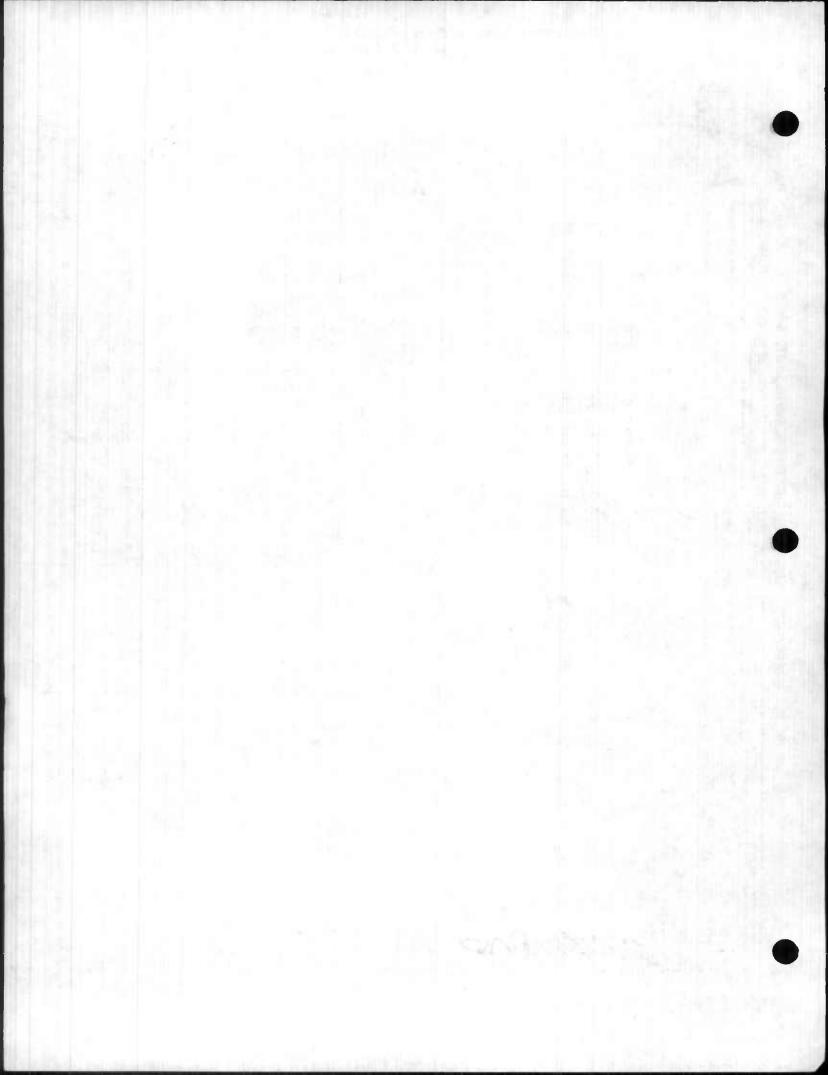
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b, Signeture end-title of a 29c. License number 29d. Dete signed (Month. Day, Year) 10 September 28, 2000 D 37975

State Registra

Jeffery Indrisano, MD 32. Registrar's Signature

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print)

10801 Lockwood Drive, #280, Silver Spring, MD



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev **Physician** September 22, 2000 Margaret M. McCarthy 11:05 am /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Montgomery General Hospital Olney Montgomery 8. Date of Birth (Month, Dey. Year) Jan 1, 1917 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplece (State or Foreign Country) New York **Funeral** Deys Hours 1□ M 2\ F Months 83 097-10-7593 Director Usual Residence of Deceden the Meryland 10a State 10c. City, Town or Location 10d Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 23a-4 show traumatic event, the Massical Examinat must be notified as 1 ☐ Yes 2 X No Maryland | Montgomery Directo Rockville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 3 Gruenther Court 20851 USA Funeral filed within 72 hours efter death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, 11. Marital Stetus 12 Was Decedent Ever In U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. Own Home 12 Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Pages 1 and 2 should be file ment of Health end Mental Hyant: If Item 27 Is marked oth jury or other traumatic even John M. Murphy Mary Katherine McLoone 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Intorment's Neme/Reletionship (Type, Print) 3 Gruenther Court, Rockville, MD 20851 Charles G. McCarthy / Husband 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State Gate of Heaven Cemetery 9/26/00 Silver Spring, MD 4 ☐ Donetion 5 ☐ Other (Specify) Departm 22. Name end Address of Fecility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licensee 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner physician and as the buriel-trensit that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence ot) nding pl for u Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causs of death? detech 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown p sign d be 24b. Were eutopsy tindings eveilable prior to 24e. Wes en eutopsy Completed completion of ceuse of deeth? After this certificate has funeral director, page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 24 hours efter death. Funeral Director: After this certificately filled in by the funeral director, 25. Wes cese reterred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a
To the Funeral D
completely filled 1 Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner ss steted.

2 Medicel Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner stated. edicai 29a. Certifler To the 29b. Signeture end title of 29d. Date signed (Month, Day, Year) 033357 00 10 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 5730 WISCARIA

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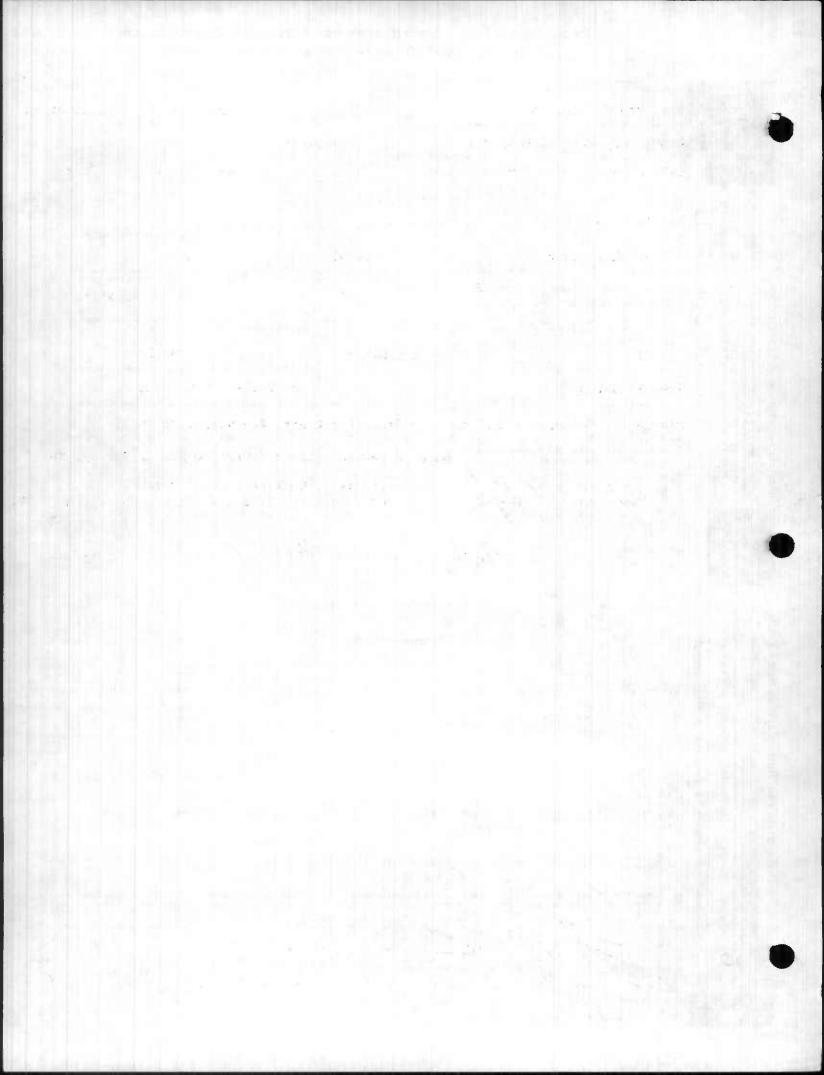
32. Aegistrer's Signeture

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State Registrar 10

31. Date filed (Month, Day, Year) SEP 2 5



State of Maryland / Department of Health and Mental Hygiene 🗍 🗎 Certificate of Death Reg. No.

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Sept.22,2000 6:18 PM Nina Maria Marriott /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 6 Say 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Hours 1□M 2[¥F Months Days 55 098-34-4656 New Director June 16,1945 Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Insida City Limits "naturel", or items 23a or 28a-f show Of Yas 2 □ No Director Washington, D.C. none none 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4545 MacArthur Blvd., N.W. #107 U.S.A. 20007 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after compensation of Heelth end Mental hygiene.
Important, if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examines and Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: by white 3 ☐ Widowed 4 ♣ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurateur Businesswoman 18. Mother's Name (First, Middle, Maiden Sumama) 17. Fethar's Nama (First, Middla, Last) Margo Harrow Jules Jacobs 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Anjulie M. Marriott/daughter 4545 MacArthur Blvd., NW, #107, Wash., D.C. 20007 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Dauriai 2 □ Cramation 3 □ Removal from Stata Sept 2000 Columbia Gardens 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
DeVol Funeral Home 2222 Wisconsin Ave., NW., Washington, DC 20007 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one ceuse on each line. Approximate Interval Between Onsat and Death Physician Cardio. Pulmo nary /Medical Immediate Ceuse (Final Hour disaase or condition rasulting in death) Examiner Multiple Sclerosis Examiner Advanced physicien and the burial-transit law requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): SE for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? isigned by the 1 Yes 2 No 3 Probably 4 Unknown to Thrive Fa: Lure þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy is certificata has director, pega 2 The 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examinar? 26. Place of Death (Check only one) examinar≀ 1 X Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred Certification: 1 Netural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation

el or Attending Physicien: T s after deeth. Il Director: After this certificat ed in by the funeral director, p To the Hospital or within 24 hours aft To the Funeral Di completaly filled in

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Medical

12 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. Licanse number

29b. Signature and title of cartifier Tu Jan

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

D0030111

September 23, 2000

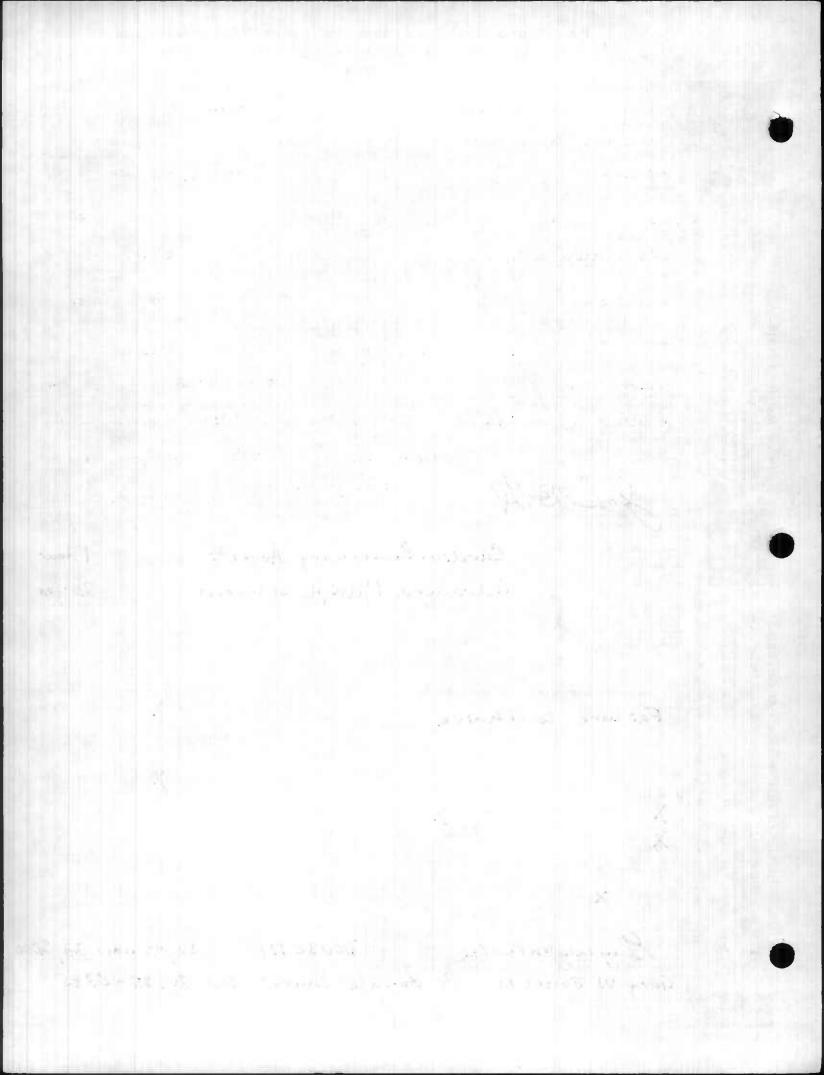
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and eddoss of person who completed cause of death (Item 23a) (Type, Print) Box 385 Laurel Md 20725 - 0385 31. Date ffled (Month, Dey, Year) SEP 2 8 2000

Registrar

32. Registrar's Signature

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) De September 16 **Physician** 2000 0709 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Yeer Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Deys Hours 1 MM 2□ F 109-03-4936 Usuel Residence of Decedent Yrs. **Director** NEW 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iN Yes 2 No BRON Director 10g. Citizen of Whet Country? 10s. Street and Number 10f. Zip Code KOAD 21830 Funeral WALK USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 2. Was Decedent Ever in U,S. Armed Forces? 11 Meritel Status Armed Forces? 1 X Yes 2 No ARMY If Yes, Give Yeer or Detes: WWII 1 Never Merried 2 Merried 1□ Yes 2RNo Specify: BLACK 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be YEARWOOD To 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HEBRON, MD, 21830 e 20c. Location - City or Town, State 7399-CHERRY WALK RD. YNTHIA MICHAEL 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20e. Method of Disposition Cremetion 3 Removel from State MARTIN LUTHER KING MEM. GROW 9/21/2000 BALTIMORE, MU. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses BENNIE SMITH 22. Name end Address of Fecility 917-W ISABELLA ST. SAUSBURY, 21801 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximate intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in death) Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown Be Completed by 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Wes an autopsy performed?

Physician /Medical Examiner

8 238

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mil. Pages 1 and 2 should be partment of Health and Mental I ordant: if Nem 27 is marked of

Baltimore, Maryland 21215-0020

109-03-4936

MICHAE

Medical Certification: To

25. Wes case referred to medical

SEP 1 9 2000

1 Yes 2 No

27. Menner of Death

1 Neturel 2 Accident

3 Suicide

29a. Certifier

4 Homicide

signed by the Hospital or Attending To the Hospital of within 24 hours at To the Funeral D completely filled in

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner steted. 29b. Signature and title of certifier

1 Unpatient

28e. Date of Injury (Month, Day Year)

2 ER/Outpatient

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of

20 License number

28c. Injury et Work?

1 Yes 2 No

3D DOA

29d. Dale signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

1 TYes

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

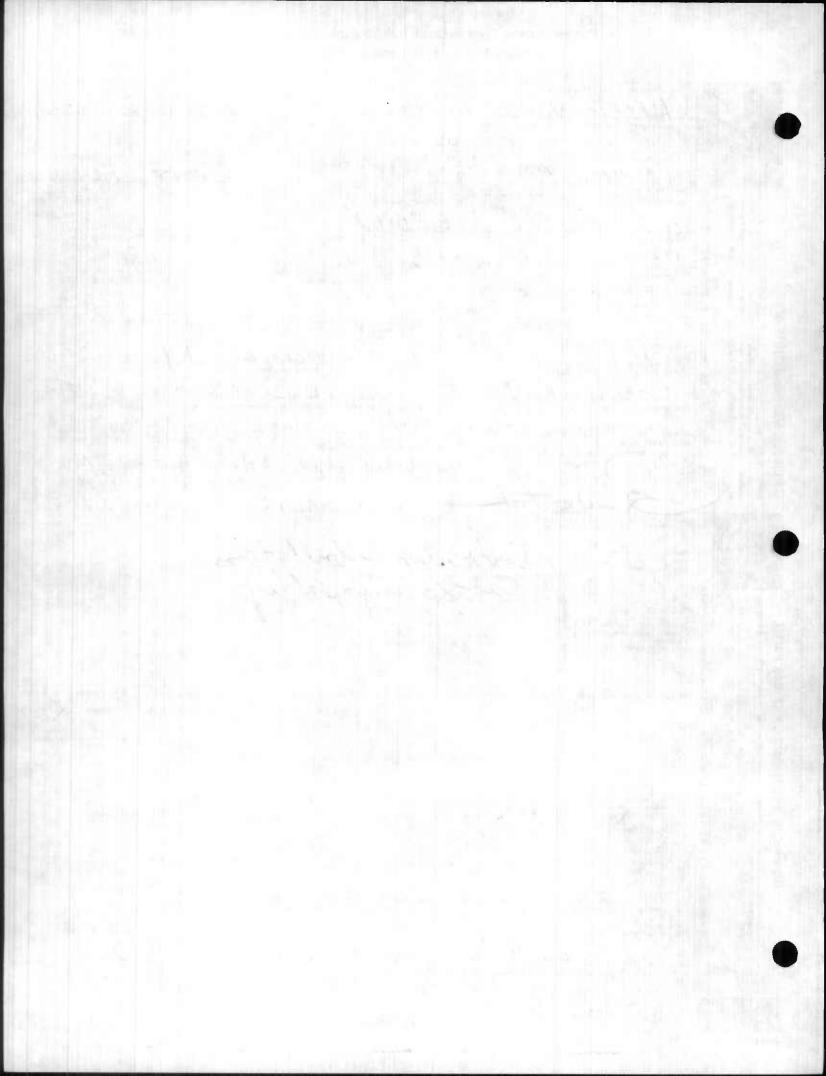
arm 30. Name and eddress of person who completed cause of death (Item 2) (Type, Print) Meyer Benjamin

Hospitel:

5 Pending investigation

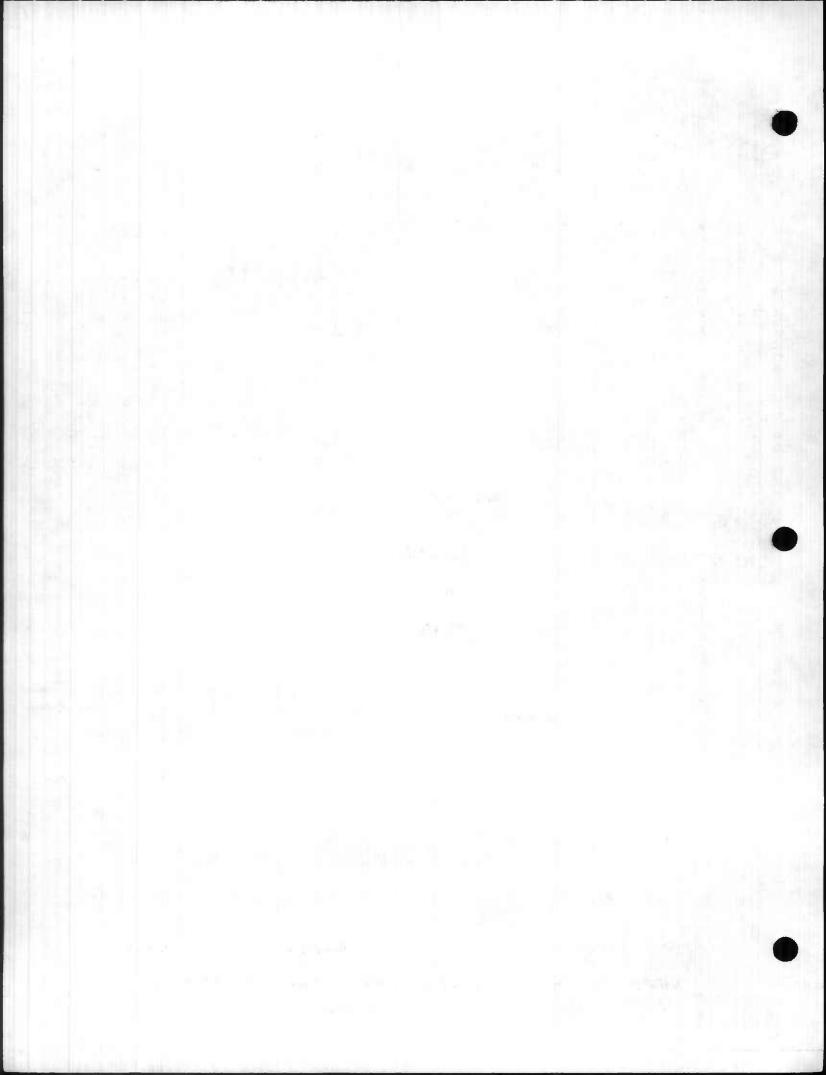
6 Could not be determined

400 Eastern Shores 32. Registrer's Sign



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month MARY McDEVITT SEPT. 20 2000 6:05 PM E. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WATERVIEW HEALTHCARE CENTER SALISBURY WICOMICO If Undar 1 Yaar If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 TF Hours Yrs Director 204-38-9302 JUNE 30,1913 PENNSYLVANIA Usual Residence of Decedant 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ahow r than "natural", or flems 23s or 28s-f show the Medical Examiner must be notified at 1X Yes 2 No Director MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 105 TIMES SOUARE 21803 U.S.A. Funeral death 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarlcan Indian, 11. Marital Status Black, White, etc. hours after 1 Nevar Married 2 Married 1 ☐ Yas 2 No If Yes, Give Yaar or Dates: altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Important: if Itam 27 is marked oth any liqury or other traumatic avant Pages. Be JOHN **ESCHBACH** ELIZABETH ALEXANDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NACRELLI - DAUGHTER 1000 SCHUMAKER WOODS RD SALISBURY, MD 21804 20b. Placa of Disposition (Name of cematery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PETER & PAUL CEMETERY 09/25/00 SPRINGFIELD, PA 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility 705 E. MAIN ST. Misse SALISBURY, MD 21804 BOUNDS FUNERAL HOME, INC. 23a. P. 11. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediate Cause (Final Preumonia disaasa or condition resulting in death) Examiner Due to (or as a consequence of): Examiner CHF requires that the death certificate be executed physician end is the burial-trans Sequentially list conditions, if any, leeding to Immadiate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): 68760 ASCUD Physician/Medical Due to (or as a consequenca of): 88 Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t semen hic Records. Aq 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? page 2 1 ☐ Yas 2 KNo certificate of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifical etely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 412 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. tnjury at Work? Division 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicida 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled i 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of cartifiar 29c. License number 29d. Date signed (Month, Day, Year) when 9/21/00 147094 SIC 30. Nama and eddress of person who completed cause of death (Item 23a) (Type, Print) MD 21804 STREET MI) SHLISBURY NATEJAN, 106 MILFORD 31. Date filed (Month, Day, Year) SEP 2 2 2000 A Registrar's Signature State souks! Registrar



Physician

/Medical

Examiner

Funeral

Director

28a-f ahow must be notified at

6

Нета 23а

traumatic event, the Medical Examiner.

other

6 permit. Page Department of Important: If any Injury or once.

Physician

The lew requires that the death certificate be executed

or Attending Physician:

of Vital Records,

Division

/Medical Examiner

end

page 2 should be deteched

this certificate has been signed by

neral Director: Aft filled in by the fur

To the Hospital
within 24 hours a
To the Funeral C

the

Physician/Medical Examiner

Be Completed by

Certification: To

Medical

ģ

Completed

Pages 1 end 2 should be filed within 72 hours sfler onent of Heelth end Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite

Maryland

Saltimore,

236-36-1

LEONARD MORELAND

with the Marylend

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Day Moreland C. September 25, 2000 5:20 A.M. 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Cumberland

er | ff Under 24 Hrs. | 8. Date of Birth
ys | Hours | Min Sep 1, 1926 Allegany Memorial Hospital & Medical Center If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) XIOM 20F Months Deys Yrs. 74 236-36-1524 Usual Residence of Decedent 10a Stete 10c. City, Town or Location 10h. County 10d. Inside City Limits 1 Yes X2 No Ridgeley Mineral

Directo 10e. Street end Number Route 2 Box 258 Funeral 11. Marital Status

1 Never Merried 2 Merried

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

 Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes → □ No Specify:

26753

14. Race - American Indien, Bleck, White, etc. Specify: white

16b. Kind of Business/Industry

20c. Location - City or Town, Stete

10g. Citizen of Whet Country?

USA

15. Decedent's Education (Specify only highest grede comp Elementary/Secondery (0-12) 12

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) retired pipefitter

10f. Zip Code

Contracting

17. Fether's Neme (First, Middle, Last) Benjamin Cleveland Moreland

18. Mother's Name (First, Middle, Maiden Surneme) Anna P Culp

19a. Informant's Name/Reletionship (Type, Print) Leona Moreland

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Route 2 Box 258; Ridgeley WV 26753

Web. Method of Disposition

X□ Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece)

9/27/ 2000 Fort Ashby, WV

Fort Ashby Cemetery Scarperin Funeral Home, P.A.

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one eduse on each line.

College (1-4or 5+)

Cumberland, MD 21502

Immediate Ceuse (Finat diseese or condition resulting in deeth)

Due to (or es e consequenca of):

Approximate Intervel Between Onset and Death

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or es e consequence of)

Due to (or es e consequence of)

Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

1 Yss 2 No

3 Probably 4 Wiknown

24a. Wes an eutopsy performed?

24b. Were autopsy findings available prior to completion of cause of deeth?

1 Yes

200 26. Piece of Death (Check only one)

1 Yes

21502

25. Was case referred to medical 1 Yes 2 1No

27. Manner of Deeth Naturel 5 Pending 2 Accident investigation

6 Could not be determined

1 Impatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Dey Year)

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury et Work? 28b. Time of 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

Cumberland, MD

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a Certifier

3 Suicide

4 Homicide

Canadying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the ceuse(s) end menner as stated adical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier 29c. License number D0054426

29d. Date signed (Month, Dey, Year)

wo. 30. Name and address of person who completed cause of doubt (line, 23e) (Type, Print) 500 Memorial Avenue, Suite 105

September 25, 2000

Dr. Michael Zang, Memorial Hospital Medical Building, 31. DeSEP 1/Nonts. Day Year

32. Registrer's Signature

DHMH 16 Rsv 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 0 1 4

			Certificate of	f Death	R	eg. No.		
Physician /Medical	1. Decedent's Name (First, Middle, Las Frances St		Carty		2. Data of Deat Month 9-7-20(Day	Yaar	3. Time of Death 4:10a.m.
Examiner	4a Facility Name (#f not institution, give	al		4b. City, Town, or Cumberla	Location of Death	4c. County	of Death	
Funeral Director	5. Social Security Number 6. Security 11	7. Age (In yrs. last	birthday) If Under 1 Ye Months Day		Aug 15,	Y1921	9. Birthple	A State or Foreign
death with the Marylend ms 23s or 28s-f show r must be notified at	Usuat Residence of Decedent 10a. State 10b. County MD Allega		own or Location Cumberland	ì			10	od. Inside City Limits
th with the Mar 23a or 28a-f si unit be notified al Director	10e. Street and Number 550 Rose Hill A	venue	10f. Zip Code	21502	1	0g. Citizen of V USA	Vhat Counti	ry?
urs after al., or its Evaration by Full		12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)	Blac	e - America k, White, e whit	tc.
within 72 ions. then "net in the Medic	15. Decedent's Ed (Specify only highest grad 1Elementery/Secondary (0-12)	College (1 Acr 5)	6e. Decedent's Usual Occ (Give kind of work do life. DO NOT use ref rmer Emplo	ne during most of wo ired)	working 16b. Kind of Business/Industry Burton's Clothir			
E T S S	John Henry Winte	erstine		18. Mother's Na Duetta	s Name (First, Middla, Maiden Sumame)			
	19a. Informant's Name/Relationship (7 Dennis McCarty	(ype, Print) 12	9b, Mailing Address (Str. 028 WIShII	eet and Number or R	ural Route Number Lan; Cum	cily or Town, berlan	State Zip (² 21502
Semit. Pages 1 end Depertment of Health mportant: If Item 27 any Injury or other to 2002.	20a Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Othar (Specify	Removal from State came	of Disposition (Neme of etery, crematory or other) awn Memori	1				
Depertment Important: any injury phose.	21. Signature of Funeral Service Licen	1 Margal	-	and, MD		, P.A.		
Physician /Medical Examiner Examiner	Sequentially list conditions,	a. ADENOCAR Due to (or as	CIND MA a consequenca of):	COLOR	3		1	Onset and Death
certificate be rding physicia use as the bur VMedical	cause. Enter Underlying Ceuse (Disease or injury that infliated events resulting in death) Last	cDue to (or as						
ss that the death or gned by the attent be detached for us by Physician	Part II. Other significant conditions co	ntributing to death but not resultin	g in the underlying cause	given in Part I.	23b. Did tobacco use contribute to the cause o			
	LORONARY	ARTERY D	ISEASE		24a. Was a			re autopsy findings illable prior to npletion of cause
The law ate hes page 2					1 🗆 Y	es 2 🕅 No	of d	leeth?
ysician: is certific director	25. Was case referred to medical examiner? 1 Yes 2 No	Hospitel: 1፟ Inpatient 2 ☐ ER	/Outpatient 3□ DOA	Other:	ath (Check only or		er (Specity)
Per Per Po	27. Menner of Deeth 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Dey Year)	M	njury at Vork? Yes 2 No		be how injury occurred		
To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At completely filled in by the It. Medical Certification	4 Homicide determined 29a. Certifier 1 Certifying Physics		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
the Hospi hin 24 hou the Funer npletely fil	(Check only 2 Medicat Exam	relcian: To the best of my knowled iner: On the basis of examination and manner stated.	and/or investigation, in m	y opinion, death occ	urred at the time, d	ate and placa,	and due to	the cause(s)
Tour	29b. Signatura and title of certifier	n.2	D001	ensa number L4865		29d. Data signed (Month, Day, Year) September (3,72000		
MAS State	30. Name and address of person who of Barrera, Robusti 31. Date & Parth 97.2000		Memorial Med	lical Bldg	., Cumbe	rland,	Maryl	and 21502

stores in horder

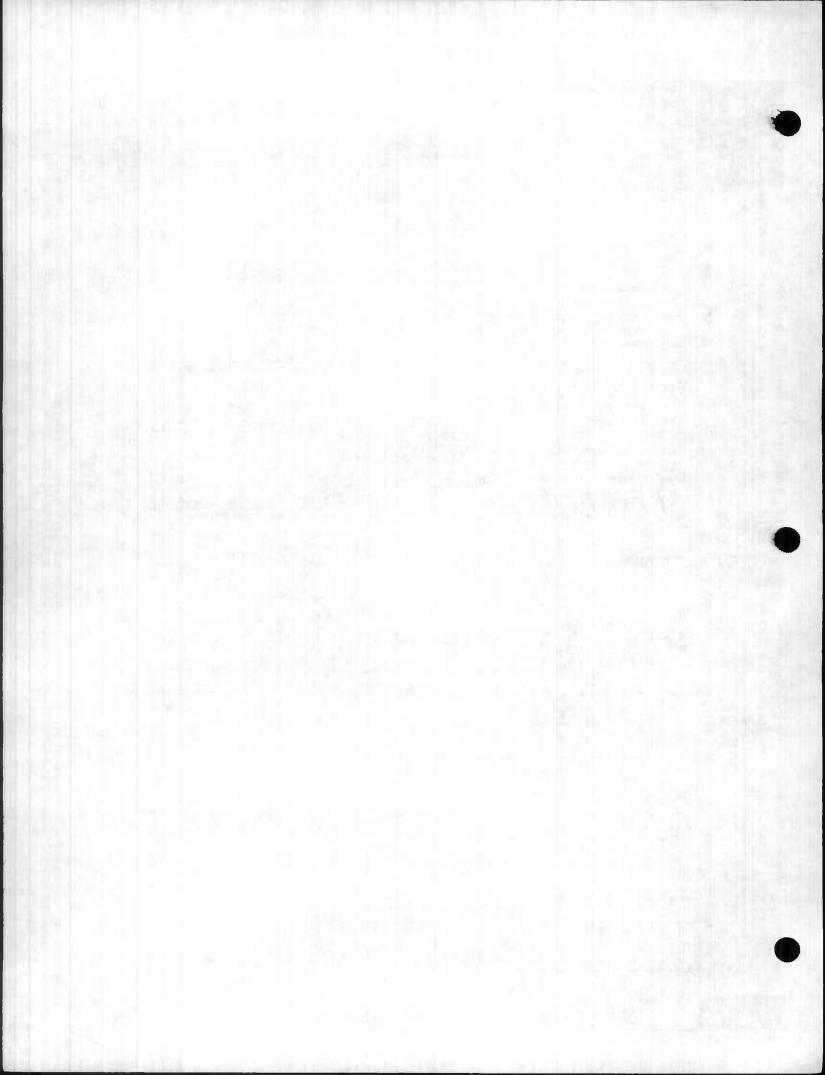
SEP 1 9 2000

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept. 14, 2000 **Physician** 10:45 AM Edward L. Morris, Jr. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9202 Cropper Island Road Newark Worcester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Feb. 6, 1939 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Massachusetts **Funeral** Months 465-60-6257 61 Director Usual Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or Herne 23a or 28a-f ahov 1 ☐ Yes 2 No must be notified Directo Worcester Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21841 U.S.A. 9202 Cropper Island Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (A Yes 2 □ No If Yes, Give Year or Dates: Marines Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status the Medical Examiner 72 hours after 1 Never Married 2 Married Specify: White 1 Yes 2 No Maryland 21215-0020 Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. fore. Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental L. Morris, Mary Redman Edward 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) restment of health an important: if item 27 is n any injury or other 2005s. L. Morris Jane 9202 Cropper Island Road Newark, Maryland 21841 Baltimore, 20a. Method of Disposition
1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 9/16/00 Salisbury, Maryland 22. Name and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Licensee M01051 23a. Part1. Enter the disease, or complications hal caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer failure. List only one ceuse on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Roff! SSV. YEORS Examiner Due to (or as a consequence of) Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician Box 68760. Physician/Medical Due to (or as a consequence of) ed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 2 No 1 Yes 3 Probably 4 Unknown þ Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 1 No 1 Yes 1 Yes 2 No or Attending Physician: director 25. Wes case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 Other (Specify) this 27. Magner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural 5 Pending 1 Yes 2 No death. 2 Accident investigation after death.

Director: A 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours To the Funeral completely filled Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

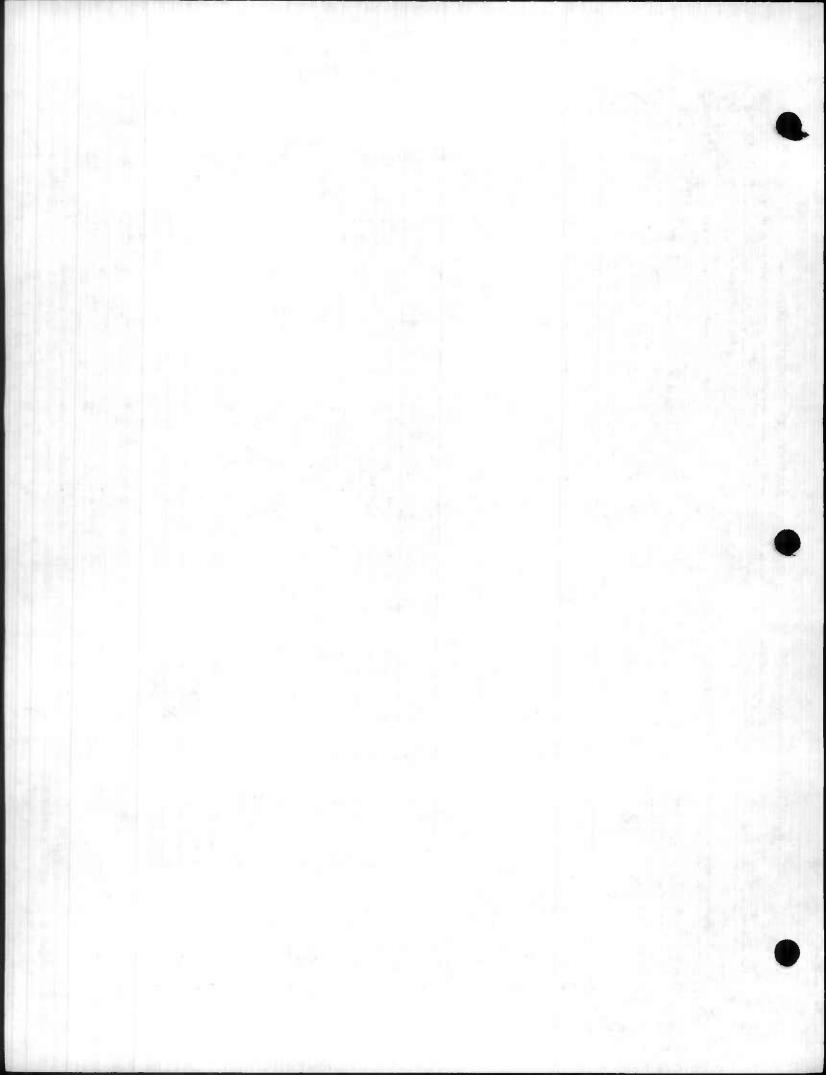
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License numbe 29b. Signature and title of certifie 29d. Date signed (Month, Dey, Year) 50 4 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 31. Date filed (M) Day, 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene 32016

			Certificate of	Death	Reg.	. No.	02010	
Physician	1. Decedent's Name (First, Middle, Las	Q M	1 Namara		2. Date of Death Month October	Day Yaar 2, 2000	3. Time of Death 6:00am	
/Medical Examiner	4a Facility Name (If not institution, give			4b. City, Town, or Lo		4c. County of De		
20	Howard County Gene	eral Hospital	ad metallic	Columbia		Howar	d	
Funeral Director	5. Social Security Number 6. St 216 20 3778	9x 7. Age (In yrs. Ia ☐ M 20XF 76	Ast birthday) If Undar 1 Yaar Months Days		8. Date of Birth (Month, Day, You May 26,		inholace (State or Foreign Country) aryland	
land land	10a. State 10b. County	10c. City	, Town or Location	72-11-2-11			10d. Inside City Limits	
death with the Maryland me 23e or 28e-f show create the notified at neral Director	Maryland Howard]	Ellicott City	1	100	. Citizen of What C	1 Yes 2 XNo	
with with				. 40	log	United		
free death w	4921 Eastwood Place	DE 12. Was Decedent Ever in U,S	S. 13. Was Decedent of If Yes, specify Cul		ecify Yas or No-	14. Race - Am		
urs after L'. or the by Fue	1 ☐ Navar Married 2 ☐ Married 3 ₺ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cul		Rican, etc.)	Black, Wh	white	
72 hours 72 hours orested by	15. Decedent's Ed (Specify only highest grad	ucation	16a. Decedent's Usual Occu	ina 16	b. Kind of Busines	s/Industry		
1 21215-0 ed within 72 ho ygiene. or than natur rt, tre Medical Completed	Elementary/Secondary (0-12)	Collega (1-4or 5+)	(Give kind of work done life. DO NOT use retin	ed)				
nd 212 e filed within al Hyglena. other then vent, the B		4	Teacher	40.44.0	VE: 1.00 (4)	Educati	on	
Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic event	17. Father's Name (First, Middle, Last)				Maidan Sumama)			
Marylan 12 should be h and Mental 18 marked reumatic ev	George Brunner			Catherine				
ire, Maryland s 1 and 2 should be files f Health and Mental Hy them 27 is marked othe other traumatic event,	19a. tnformant's Name/Relationship (7		19b. Mailing Address (Street					
other to	Chris McNamara/Son		5639 Bartholo	w Road Syl		oc. Location - City of		
To aga	Burial 2 Cremation 3 4 Donation 5 Other (Specify	Ramoval from State Gari	metery, crematory or other plants on Forest \	7et. Cem.10	0-6-2000	Owings M	ills, MD	
Balting parmit. Pa Department Important sny injury pnce.	21. Signature of Funerel Service Licen	Chip- At L	Harry H. 4112 Old	Witzke's I Columbia I	Family Fu Pike Elli	neral Ho	me, Inc. y, MD 21043	
	23a. Part1. Enter the diseasa, or composhock, or heart failure. List only	olications that causad tha death					Approximate Intervel Between	
Physician /Medical Examiner	Immediete Cause (Final disease or condition resulting in death)	a. CVA	as a consequence of):				Onset and Death	
i manual is								
be executed cian and burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Undartying Cause (Disease or injury that initiated events	b. Due to (or	as a consequence of):					
entificate ing physics as the Medic	Cause (Disease or injury that initiated events rasulting in death) Last	C. Dua to (or	as a consequence of):					
Band Sand		u				100		
obed shed	Part II. Other eignificant conditions co	entributing to death but not resu	Iting in the underlying cause g	iven in Part I.	23b. Did toba	acco use contribu	te to the cause of death?	
S, P.	HTN, A	ODM, Ken	not daily	Ψ.	1 🗆 Yee	No 3□	Probably 4 Unknow	
VITAI RECORDS, P.O. BO) slicient: The law requires that the destrict certificate has been signed by the attend frector, page 2 should be delached for us o Be Completed by Physiciany	DM Newogat	thy, Chro	mic Atel	ectari	24a. Was an a		Were autopsy findings available prior to completion of cause of death?	
E The It The Control of Com	Kesprati	LNSUFF	TCIPHCY		1 ☐ Yes	20 No	1 ☐ Yes 2 ☐ No	
Clan:	25. Wes case refured to medical examiner?			26. Plece of Deat	h (Check only one)			
F 2 2 2	1 ☐ Yes No		Envoulpatient 30 DOA		me 5 Residen		pecify)	
anding P anh. Tr. Ahart he funera	27. Manner of Death Netural 5 Pending a Accident investigation	(Month, Day Year)	28b. Time of tnjury M 1[ury et ork? ☐ Yes 2 ☐ No	28d. Describe how	injury occurred		
DIVISION C pital or Attending P burs after death. eral Director: After i illed in by the funeral	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Placa of Injury - At ho building, etc. (Specify	me, farm, street, factory, office)	9	28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,	
Markenplas or no 24 hours sha he Funeral Direction placesy filled in 1 edical Cert	29a. Certifier (Check only one) Certifying Phy 2 Medical Example (Check only one)	veician: To the best of my know Iner: On the basis of examinati and mannar stated.	viedge, deeth occurred at the ion and/or investigation, in my	time, date and place, opinion, daath occurr	and due to the cau red at the time, data	se(s) and manner a and place, and d	as stated. ue to tha causa(s)	
1 1 1 1 1 N	29b. Signature and title of certific	0	29c. Licer	nse number	290	d. Date signed (Mo	nth, Day, Year)	
(20.	(Vanaka) 4	Teelman	H3	7211		KT 2	, 2000	
ed	30. Name and address of person who	completed cause of death (ttem	23a) (Type, Print)	COLIMP	A MA	2104		
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure 4 /	21	0,1110			

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 03:15 AN Lillian Elizabeth Miller 31 2000 Aug /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Moran Manor Nursing Home Allegany Westernport 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days 10 M 30 F Months Hours 213-22-4400 85 1915 Director May 29, Maryland Usual Residence of Decedent the Maryland 10a. State 10b County 10c City Town or Location 10d. Inside City Limits man be notified at ¥ Yes 2 No Maryland Allegany Westernport Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rt. 1 Box 13 21562 USA Name 23a 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: White "natural", or 1 Yes No Specify: á 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hyglene. Other than 'n Elementary/Secondary (0-12) College (1-4or 5+) Club Bartender permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: if Item 27 is marked other the any injury or other treatments. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Stewart Michael Elizabeth Wilkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Clark 44 Miller Road, Barton, MD 21521 20b. Place of Disposition (Name of cemetery, crematory or other place)
Philos Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 09/02/2000 Westernport MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home Wayne 111 Church St., Westernport, MD 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Sepsis week Examiner Due to (or as a consequence of): Examiner nemonia 1 weeks physicien end the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Maknown signed to þ 24b. Were autopsy findings available prior to completion of cause of death? been s 24a. Was an autopsy performed? Completed Respiratory Failure: page 2 a Heart Failurg 1 Yes 25 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: All Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 25 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: ·4 DNatural 5 Pending investigation 2 Accident 1 TYes 2 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified chri 221244 8/31/00 30. Name and address of paragraph of paragraph of the prost of the paragraph of the paragra 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

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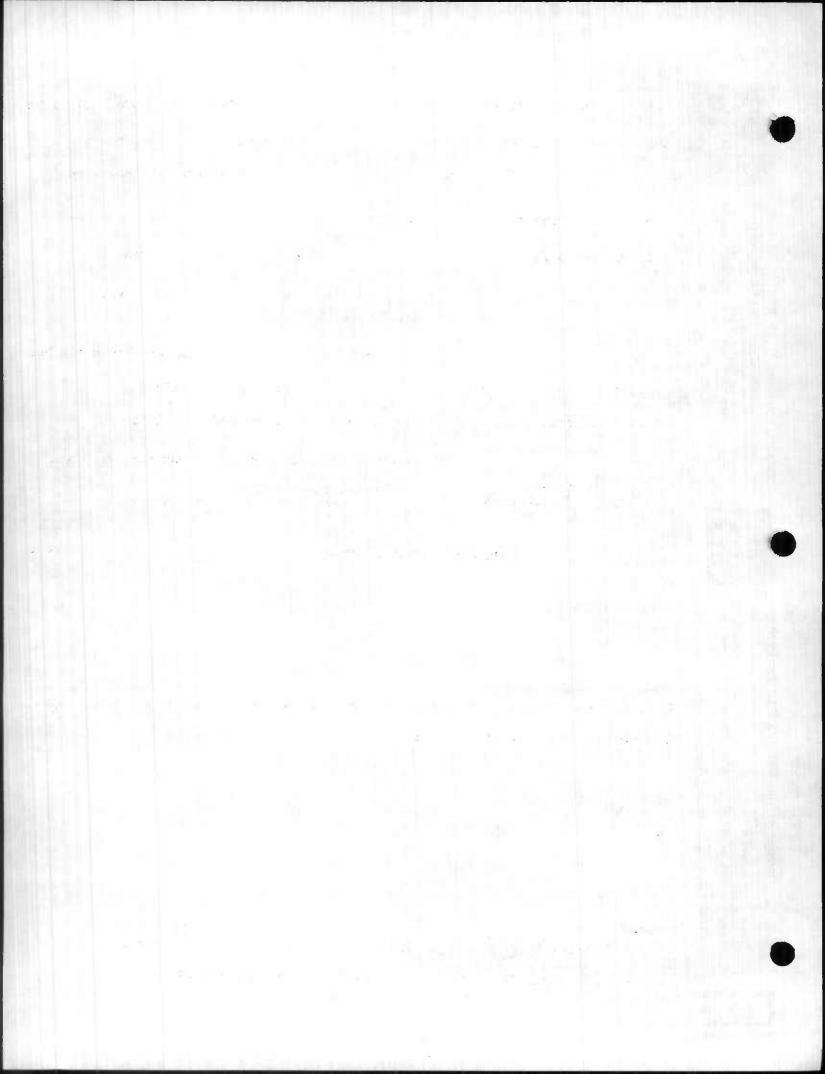
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State of Maryland / Department of Health and Mental Hygiene 1 1 2 2 1

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	Examin		4a Facility Nama (If not Institution, giv	a streat and number)				4b. City, Town, or L	ocation of Death	4c. County	of Death		
4		14	Cuppett-Weeks No	ursing Home	e			0akla	nd	G	arre	t	
	Funeral Director		213-24-6468	Sax 7. Age I□M 2∑TF	92	thday) If Und Months	ar 1 Yaar s Deys		8. Data of Bin (Month, Da Feb. 10	th y, Year) 0, 1908	9. Birthpl Count Mary.	aca (Stata o ry) Land	r Foraign
	and *		Usual Rasidance of Dacedant 10e. State 10b. County		10c. City, Tow	n or Location				10d. Inside City Limits			ty Limits
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	28a-	Director	10e. Street and Number	Lecc		1	ip Coda			10g. Citizen of W	/hat Count	rv?	
	ath with		215 N. Fourth				2	1550		US	Α		
0050	filed within 72 hours after death with the Maryland Hygiene. Hygiene. they than "natural", or flems 23s or 28s-f show ant, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Navar Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Dacadant E Armed Forcas? 1 ☐ Yas 2 ☒ N If Yas, Giva Yaar or Datas:				Hispanic Origin? (Sp an, Maxican, Puerto Specify:	pecify Yas or No Pican, atc.)	Blac	- Amarico k, Whita, a : Whita	itc.	
5-0	72 h	etec	15. Decedant's Ed (Specify only highest gre	ducetion ada complatad)	16a.	Decedent's Us	ual Occu	pation during most of work	kina	16b. Kind of Bu	sinass/Ind	ustry	
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Maryland	0 0 77 0	o Be	Archibald	Bows	er			Elva R	ebecca	Friend			
ary	2 should be and Menta is marked aumatic ev	-	19a. Informant's Name/Relationship (. Mailing Addre	ss (Stree	t and Number or Ru			Stata, Zip	Coda)	
Š			Robert B. Alexan					h St., Oa					
re,			20a. Mathod of Disposition			Disposition (Nry, cramatory or			Dete	20c. Location -		wn, Stata	
Baltimore,			1 ⚠Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specif					Gardens 9	/10/00	0akland	, Ma	ryland	l
Bal	Depart Import any In		21. Signatura of Funaral Service Licer	De St		Stewa	rt F	ess of Facility uneral Ho		2/1 01	F.F.O.		
	Physician		32 S. Second St., Oakland, Md. 21550 23a. Part1. Enter the disaasal or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Complex C										
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H	/Medical		Immediate Causa (Final disaasa or condition	Congest	tive hea	art fai	lure			5 yea			ars
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ox 68760,	law requiras that the death certificate be executed as been signed by the attending physician and a 2 should be datached for usa as the bunel-trensit	/Medical	that initiated avants rasulting in death) Last	d	Dua to (or as a d	consequanca of	sequanca of):						
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	ding Phy th. : After this s funerel o		27. Mannar of Death 1 Natural 5 Panding 2 Accidant investigation	28a. Data of Injur (Month, Day		Fima of njury	28c. Inju			how Injury occurr		,	
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	of the of the omple	Me	29b. Signature of d titla of certifiar	-	/	2	9c. Licar	sa number		29d. Date signe	d (Month,	Day, Year)	
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			30. Nama and addrass of pelson who Margaret A. Kaise		eath (Item 23a) 079 Gar	(Type, Print) rett Hi	.ghwa	y, Oaklan	nd, MD	21550			
	Sta Registra	_	31. Data filed (Month, Day, Year)		r's Signatura	4	la	relat					

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 32019

	Certificate of Death	P	leg. No.	02013								
	Decedent's Neme (First, Middle, Last)	2. Dete of Dee Month		3. Time of Death								
Physician /Medical	MAI THI NGUYEN		25, 2000	10:07 PM								
Examiner	4e Facility Neme (If not Institution, give street and number) 4b. City, Tou	wn, or Location of Death	4c. County of Dea	th								
	HOLY CROSS HOSPITAL SIL	VER SPRING	MONTG	OMERY								
Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Months Deys Hours	Min. (Month, Day	year) 9. Bir	thplece (Stete or Foreign ountry)								
Director	217-06-9456 1 46 Yrs. 46	JUNE 1	9,1954 V	IETNAM								
8 8	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits								
aho asho				1 X Yes 2 □ No								
or 28s-f s be notified Director	MD. MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zio Code	1.	10g. Citizen of What Co									
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5 3 W E	THOA DINH NGUYEN/BROTHER 5201 DUKE ST. #4	04. ALEXAND	RIA, VA. 2	2304								
2 mm 4 mm	20e. Method of Disposition 20b. Place of Disposition (Name of completely cremetory or other place)		20c. Location - City or									
semit. Pages 1 a Department of He mportant: If them iny injury or other 2008.	1 M Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) GATE OF HEAVEN CEMET	ERY 9/30/00	STIVERS	PRING, MD.								
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Deg man	> MM Chambara D.			2090								
	MOOO91 CHAMBERS FUNERA 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.			Approximete								
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1 × 100	29b. Signature and title of certifiery 29c. License number		29d. Date signed (Mon	m, Day, Year)								
	De 3539		SEPT. 25	, 2000								
	30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)											
	RAYMOND M. WHITE, M.D. 1500 FOREST GLEN RD., S	ILVER SPRIN	IG, MD.									
State	31. Dete filled (Month, Dey, Year) 32. Registrer's Signeture											
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey **Physician** RUTH SEPT. NICKENS 24, 2000 4:28 AM /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL | IANUPA | I TAKOMA PARK MONTGOMERY 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 5. Sociel Security Number **Funeral** 1□M 2[XF Yrs. 577-38-1223 69 Md. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 No Yes 2 No Director Prince George's Hyattsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code В Rems 23s 5009 40th Place #T-4 20781 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Bleck, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Merried 6 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced **Black** Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. should be filed within Elementary/Secondery (0-12) College (1-4or 5+) 11th Laundry Worker Laundry 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) nd Mental marked o Mary Robinson Charles Noland and all 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If them 27 is m If Health Item 27 Keema Richardson / Granddaughter 5009 40th Pl., #T-4 Hyattsville, Md. 20781 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 ₺ Burial 2 Cremetion 3 Removal from State Forest Hills Mem. Gardens 9-30-00 Clinton, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeret Service Licens 22. Name end Address of Fecility Capitol Mortuary, Inc. arri 1425 Maryland Ave., NE Wash., DC 20002 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** . PULMOHARY EDEMA, CARDIACARRHYTHMIAS tmmediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner COROHARY ARTERY DISEASE 3 HYPERTERSION Due to (or es e consequence of): 3 LEFT VENTRICULAR DYS FUNCTION The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Box 68760. that initieted events resulting in death) Last Due to (or es e consequença of) P.O. 1 Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown TES MELLITUS of Vital Records, Completed by 24a. Wes an eutopsy performed? 24b. Were autopsy findings evailable prior to GBSTNETIVE PULMONARY DISBASS completion of cause of deeth? 2 No 1 Yes 1 ☐ Yes 2 ☐ No lal or Attending Physician: The start death.

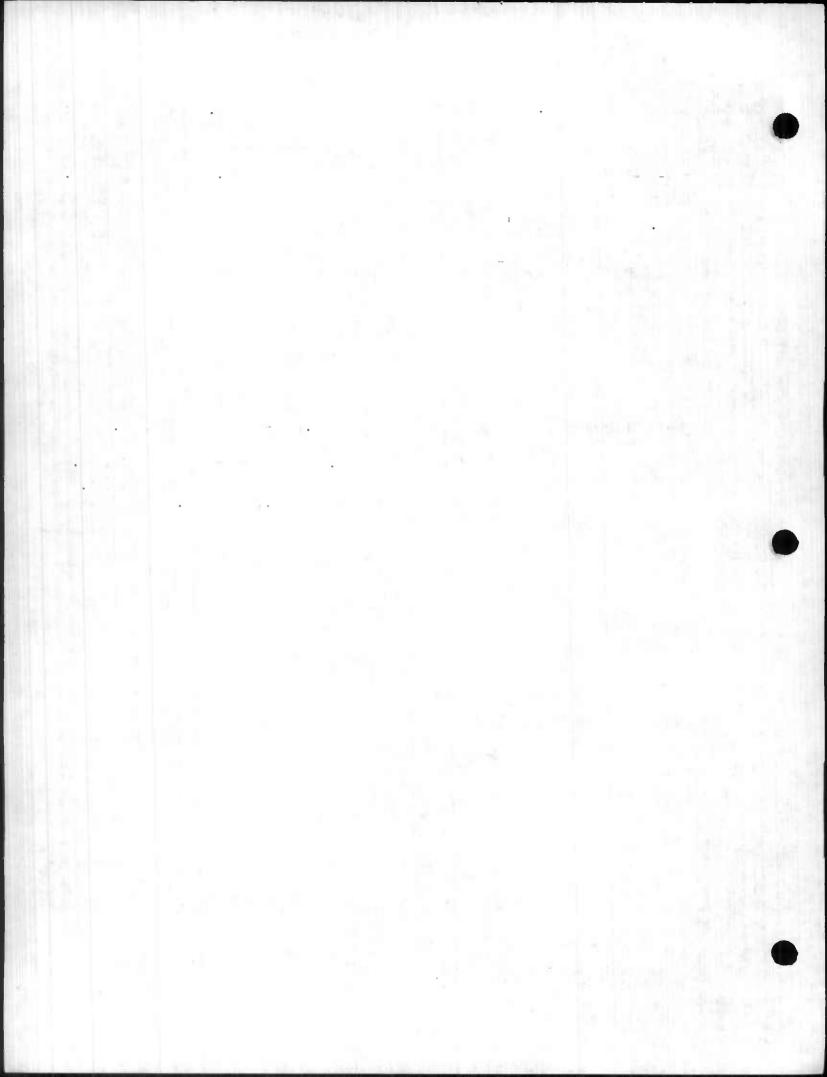
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In Director: After this certificated in by the funeral director, pages. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 PR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Yes 2□ No 28a. Dete of Injury (Month, Dey Year) 27. Menger of Deeth 28d. Describe how injury occurred 28c. Injury et Work? Division 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner steted. 29a. Cartifier (Check only one) 29b. Signature and title of certifier 29d. Dete signed (Month, Dey, Year) A. Marman MD 29c. License number 9,26,00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3331 - TOLE DO TENNACE MOHAMMED A. MANNAN MD. 3 347ATTS VILLE, M.D. 20782

State Registrar 32. Registrar's Signeture

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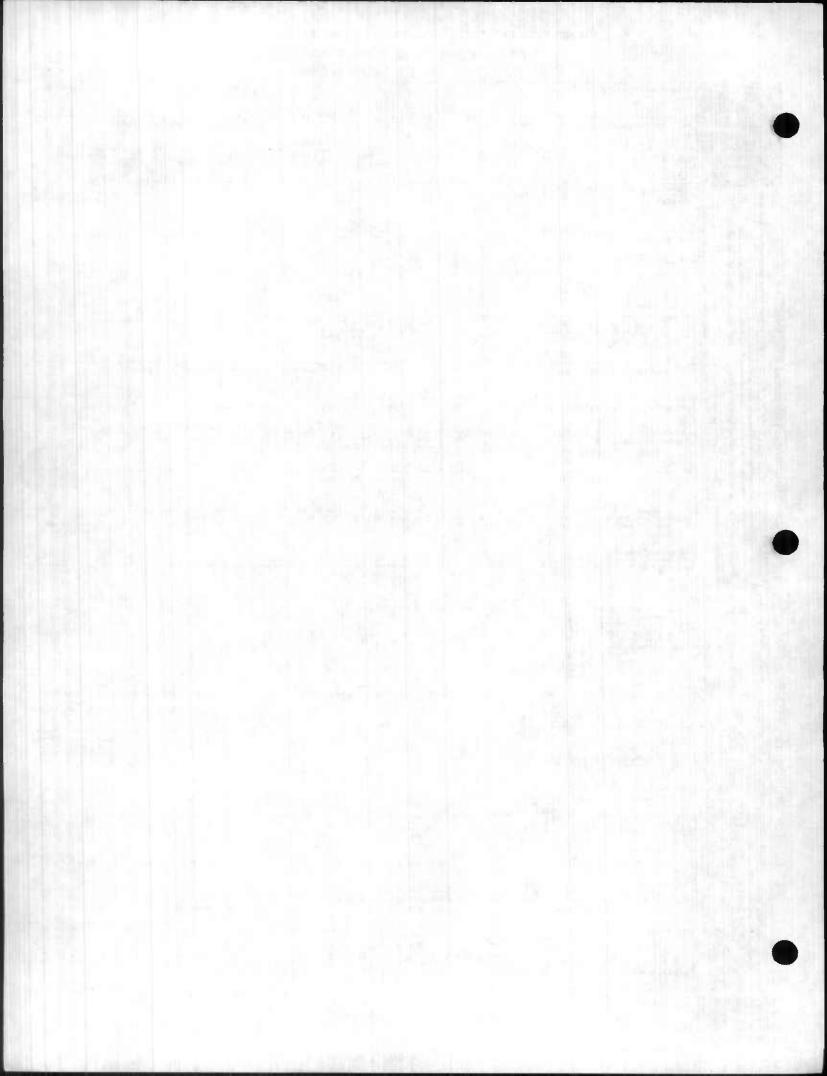
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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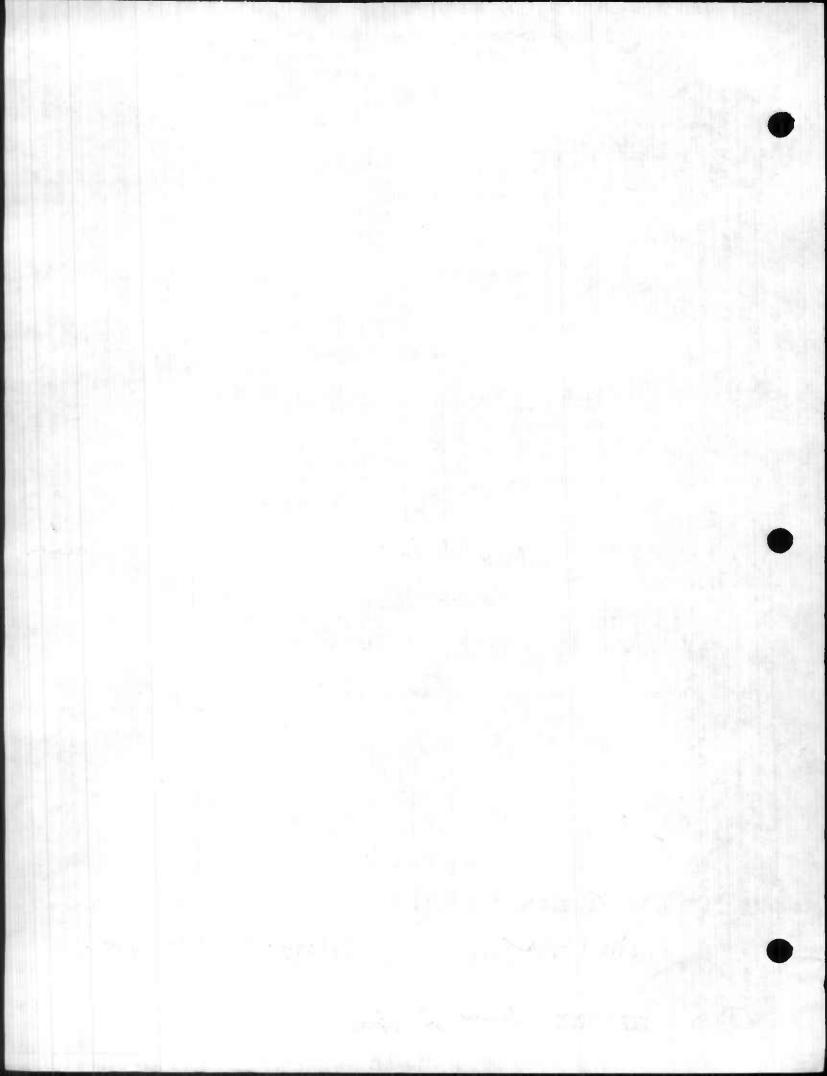
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	<u> </u>		Montgomery Ho						Under d Vend	Rocky			Mont	gome	ry	
	Funeral		5. Social Security Number	6. Se	x 7. □M 25√F	Aga (In yrs	. Y		Undar 1 Yaar onths Days		Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	olaca (State or Foraig ntry)	(n)
L	Director		073-09-0017 Usual Residence of Decedent			94	4		_	1		April 4	, 1906	New	York	
	Aand		10a. State 10b. County	,		10c. C	ity, Town	or Locatio	on					1	Od. Inside City Limit	S
	Men H	tor	Maryland Mont	gom	erv		Silv	er Sr	oring						1 X Yes 2 □ N	D
	7 284	Director	10e. Street end Number						Of, Zip Code			1	Og. Citizen of V	/het Cour	ntry?	
	th wil		15310 Beaverbro	ok	Court				209	906			USA			
	after deeth with the Merylan or Items 23s or 28s-1 show prine man be motified a	Funeral	11. Maritel Stafus		12. Was Deced		J,S.	13. Wes	Decedent of s, specify Cut	Hispanic Or an, Maxica	rigin? (Spec	ify Yes or No- ican, etc.)		e - Americ k, White,	ean Indian, etc.	
21215-0020		by	1 Never Married 2 Mar 3 X Widowed 4 Divorced		1 Yes 2 If Yes, Give Yaar or Date				Yes ZE No				Specify	Whi	te	
5-0	n 72 hours natural',	Completed	15. Deceder (Specify only highs			14	16a. [Decedent's	s Usuel Occu	pation during mos	st of working	a	16b. Kind of Bu	siness/In	dustry	
21	ithin	nple	Elementery/Secondery (0-12)	ist gree	College (1-4	or 5+)		life. DO N	VOT usa retire	ed)	or or money					
	liled with Hygiene. Ather than	S		1 1	2		Во	okkee	eper	40 14-41	- de Alexan		America		1 Cross	
and	Mental H Mental H srked off	Be	17. Father's Name (First, Middla,							18. Moth	ers Name	(FITST, MIDDIE,	Maiden Sumem	e)		
Maryland	should be liled withind Mental Hygiene. I marked other than umstic svent, tree.	2	Nicholas D 19a. Informant's Neme/Relation:		arti		106	Mailing A	ddrose (Stroe	For	tunat	a L	atona Town	State 7ir	28405	-
Ma	0000															
e,	of Heelth Itsm 27 other tr		Richard J. Nas 20a. Method of Disposition	ca,	M.D.	son) 20b.	Place of I	Disposition	n (Name of		rive	W1 Imin	20c. Location	City or To	Carolina own, State	
OF	Pages nent of int: If Its		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5			ate			ry or other ple			106 100				
Baltimore			21. Signeture of Funeral Service			St	. Ma:		me and Addr		ity	26/00	Geneseo	. Nev	v York	
B	Departi Departi Importu any inju		1 Star 1	1	L. 8								Home,			
			23a. Pert1. Enter the disease, o shock, or heart feilure. Lis	r comp	lications that cau	sed the dee	th. Do no	ot enter th	Univer e mode of dy	SITY ing, such as	Blvd.	respiratory and	lver Sprast,	ring,	MD 20901 Approximate	
	Physician		shock, or heart feilure. Lis	t only o	ne cause on eed	ch line.								1	Interval Between Onset and Death	
	/Medical		Immediate Ceuse (Finel disease or condition		Chror	nic He	art 1	Fail:	ıra						l vr	
	Examiner		resulting in death)		a. OIII.OI			onsequen							ı yı	
	8 15	Examiner			Ather	oscle	roti	c Hea	art Dis	sease				1	15 yrs.	
	death certificate be executed e attending physicien and of for use es the burial-transit	xan	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			Due to (or as e co	onsequen	ca of):							
68760,	sicier buri		Cause (Diseese or injury that initiated events		c	Due to (4)·					1		
89	ng phy es the	edicai	resulting In death) Lest			Due to (or as e co	nsequenc	28 01):					1		
Вох	attendin for use	2		-	d						-			-		
	death e atte	sicia	Pert il. Other eignificant conditi	ons co	ntributing to dea	th but not re	sulting in	the under	tying cause g	iven in Pert	l.	23b. Did t	obacco use co	ntribute t	o the cause of deati	h?
P.0	es that the designed by the a	Physician/M										101	res 2□ No	3 Pro	bably 4X Unkno	wn
Ś	gned b	by	Pleural Effusi	on_											million	
Record	v requires been sign should be		Renal Insuffic	ion	227							24a. Was a perfor	an autopsy med?	av	ere autopsy findings allable prior to	
ec.	2 s b	Completed	Kellal Illsullic	Tell	_ y									of	ompletion of cause death?	
E B	The ate h	50	Atrial Fibrill	ati	on							1 🗆 Y	es 2 No	1[☐Yes 2☐ No	
Vitai	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	-	line tel						e of Deeth	(Check only o	10)			
of	£ 5 m	2	1 Yes 2⊠ No 27. Manner of Death		Hospitel: 1 In		_	patient 3	DOA				enca 6 20th ow injury occur		w Hospice	
	After funer	lon	1 ☑ Netural 5 ☐ Pendi	ng igetion	28a. Dete of (Month,	Dey Year)	28b. Ti	jury	28c. tnje W	ork?]Yes 2.□		ou. Describe n	ow injury occur	90		
isi	or Attending I after death. Director: After I in by the fune	fica	3 Suicide 6 Could	not be	28e. Piece o	f Injury - At I	nome, ferr					8f. Location (S	treet and Numb	er or Run	al Route Number,	_
Division	after after Directory	Certification:	4 Homicide determ	ninea	building	, etc. (Spec	ity)	.,	fectory, office	idh:		City or Tow	m, Stete)			
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edical C			stcian: To the biner: On the bas	is of examin										
	within 2 To the comple	Ž	29b. Signature and title of certific	er e	0.13 111411110	. 3.0.00.			29c. Licar	se number			29d. Data signe	d (Month,	Day, Year)	
	57	>	1 2	1	7	ih	0 -		D 004	.70					2002	
			30. Name end address of person	who o	ompleted cause	of death (Ite	m 23a) (T	vpe. Print	D 094	170		S	eptembe:	c 23,	2000	
			Eugene P. Libr							nue	Kened	natan	Maryland	4 20	1805	
	Sta	e	31. Date filed (Month, Dey, Year,)	32. Peg	jistrar's Sign	eture	الماليات	1		wens1	ug tull, i	ary tano	1-26	1073	
	Registra		SEP 2 5	20	UU A	nerver	13	1. 1	GOOCK.	2/						



The state of the s				
ate of Maryland / Department of Health and Mental Hygiène	00	32	02	9
Certificate of Death Bea No.		0 ==	U ha	6.4

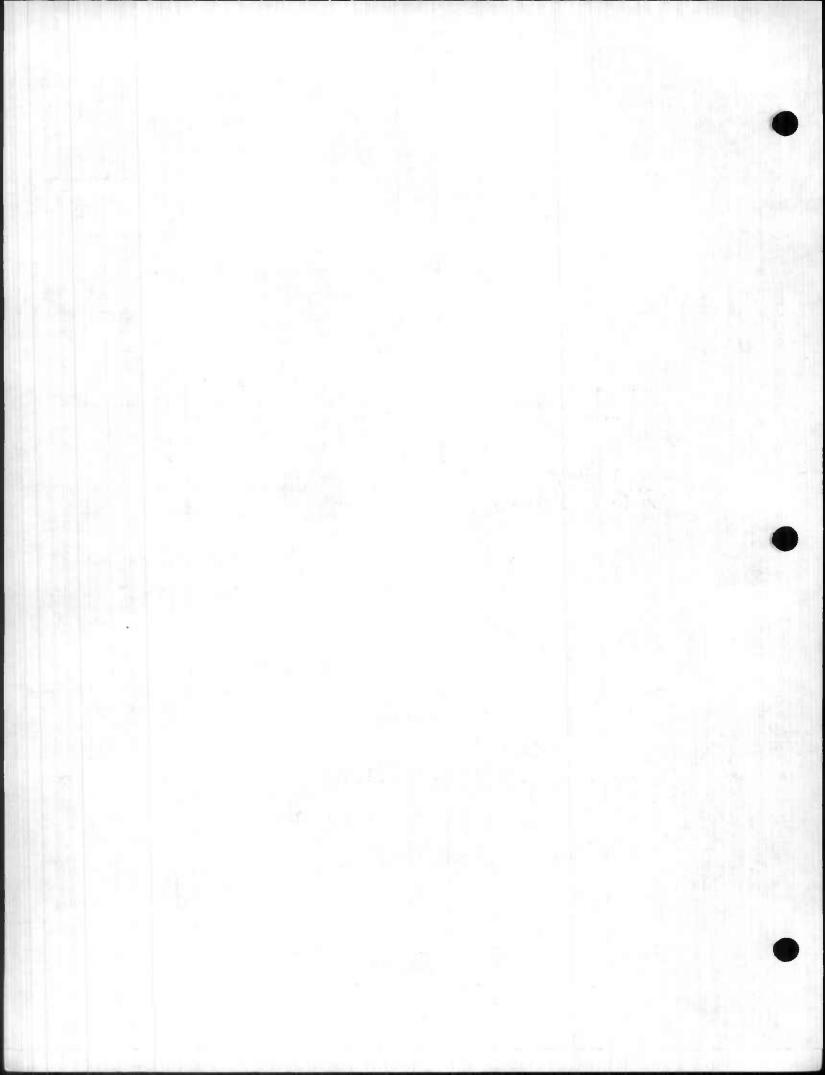
			C	Certificate	of Death	R	ng. No.	U	2026
Physiciar	Decedent's Neme (First, Middle, I	ast)				2. Dete of Deat Month	Day	Year	3. Time of Death
/Medica	KICHARD BENI	RY NORAIR, S	R			Sept	22 20	000	0400
Examine	An English Manne His not in attituden a	ive street and number)			4b. City, Town, or L	ocation of Death	4c. County o	f Death	
SQL II	Memorial				Eastor		Tall		
Funeral Director	5. Social Security Number 6. 578-36-7274	MAM SOF	In yrs. lest birtho	Months D	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, APRIL 8	Year) , 1929		ace (State or Foreign ry) PA
p .	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town o	or I contion				10	d. Inside City Limits
elyle eho								- 10	1 ☐ Yes 2 ☑ No
vith the Me t or 28a-f a	MD TA	LBOT	EA	STON	4.		On Citizen of Mil	hat Caust	
with you				10f. Zip Co			0g. Citizen of Wi		iyi
4 53 m	27825 CEDAR PO	NT RD 12. Was Decedent Eve	ar in HS	13 Was Decedent	21601	pacify Vas or No.	14. Rece	USA - America	in Indian
G Z1Z15-UUZU filed within 72 hours efter deeth with the Meryland hygiene. ther than "natural", or Nema 23a or 28a-1 show int, the Wederal Examiner must be notified at	3 □ Widowed 4 □ Divorced	Armed Forces? 1 TYes 2 No If Yes, Give Year or Dates:	SI WI 0,0.	If Yes, specify	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	Rican, etc.)	Black	White, e	tc.
72 ho	15. Decedent's		16a. D	ecedent's Usual O	ccupation lone during most of work	kha	16b. Kind of Bus	iness/Ind	ustry
be filed within 72 ho be filed within 72 ho litel Hygiene. d other then nature event, the Medical	(Specify only highest g	College (1-4or 5+)	11	fe. DO NOT use n	etired)	and a			
w bed w	12	4	CON	TRACTOR/	DEVELOPER		CONSTR		ON
		it)			18. Mother's Nam	ne (First, Middle, I	Maiden Sumame)	
should Inmerke	HRANDT NORAIR					SPEIKER			
2005	19a. Informant's Name/Relationship				treet and Number or Ru			State, Zip	Code)
C - 01 L	ALICE B. NORAIR				R POINT RD				- 0
Caltimore, mit. Peges 1 ar pertment of Hee portant: if Item 2 y Injury or other	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	cemetery,	isposition (Name of crematory or other EAKE CREI	MATION CTR9		STEVEN	1	
bernit. Peges Depertment of Important: If it any injury or o	21 Signature of Funeral Service Lie	and and Co	CSP		ddress of Facility HELFENEBIN HARRISON ST	& NEWNA	M _M EUNER	AL HO	OME PA
Physician /Medical Examiner	23a. Pert1 Enter the disease, or of shock, or heart failure. List do Immediate Cause (Final disease or condition resulting in death)	· Mesosl		á -	dying, such es cardiac				Approximate Interval Between Onsef end Deafh Mouth
g physician end es the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du	ue to (or as a con	nsequence of):					
5 0 0		Du I d	e fo (or as e cor	nsequenca of):					
death cer death cer e attendir e of for use	Part If. Other eignificant conditions	contributing to death but r	nof resulting in th	se underlying caus	e given in Part I	23b Did to	bacco uae con	ribute to	the cause of death?
es that the death certigoned by the attendir	and the state of t	gre countrout		y outo	and the second				ebly 4 Unknown
						(00)			,
required been should						24a. Was a perform		ava	re autopsy findings ilable prior to nplefion of cause leeth?
The la						1 🗆 Yı	es 2 No	1 🗆	Yes 2□ No
OT VITAL HE Physician: The lav this certificate hes ral director, page 2					26. Place of Dea	ith (Check only or	Θ)		
Physician: This certific ral director,	examiner?	Hospital: Inpatient	2 ER/Outp	atient 3 DOA	Other: 4 Nursing H	ome 5 🗆 Reside	ence 6 Othe	r (Specify)
Attending Physic deeth. Sctor: After this by the funeral di		28a. Date of Injury (Month, Day Y	(ear) 28b. Tim	ne of 28c.	Injury at Work? 1 Yes 2 No	28d. Describe he	ow injury occurre	od	
DIVISION Call or Attending P as after deeth. al Director: After tied in by the funer.	3 ☐ Suicide 6 ☐ Could not determine		- At home, farm Specify)	, street, factory, of	fice	28f. Location (Si City or Town		r or Rurai	Route Number,
Hospi 4 hou Funer tely fil	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ext	hyeician: To the best of n miner: On the basis of ex and manner stated	camination and/c	leath occurred at to or investigation, in	ne time, date and place my opinion, death occu	, and due to the corred at the time, d	ause(s) and mar ate and place, a	ner as stand due to	ated. the cause(s)
To the I within 2 To the I comple	29b. Signature and title of certifier	w			cense number 41887	2	9d. Date signed $9(22)$		Oay, Year)
	30. Name and address of person who DAVID H. SMITH				5 EASTON, M	D 21601			
State Registrar	31. Dete filed (Month, Day, Year) SEP 2 5 2000	32. Regisfrar's	Signeture .	Spark					

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

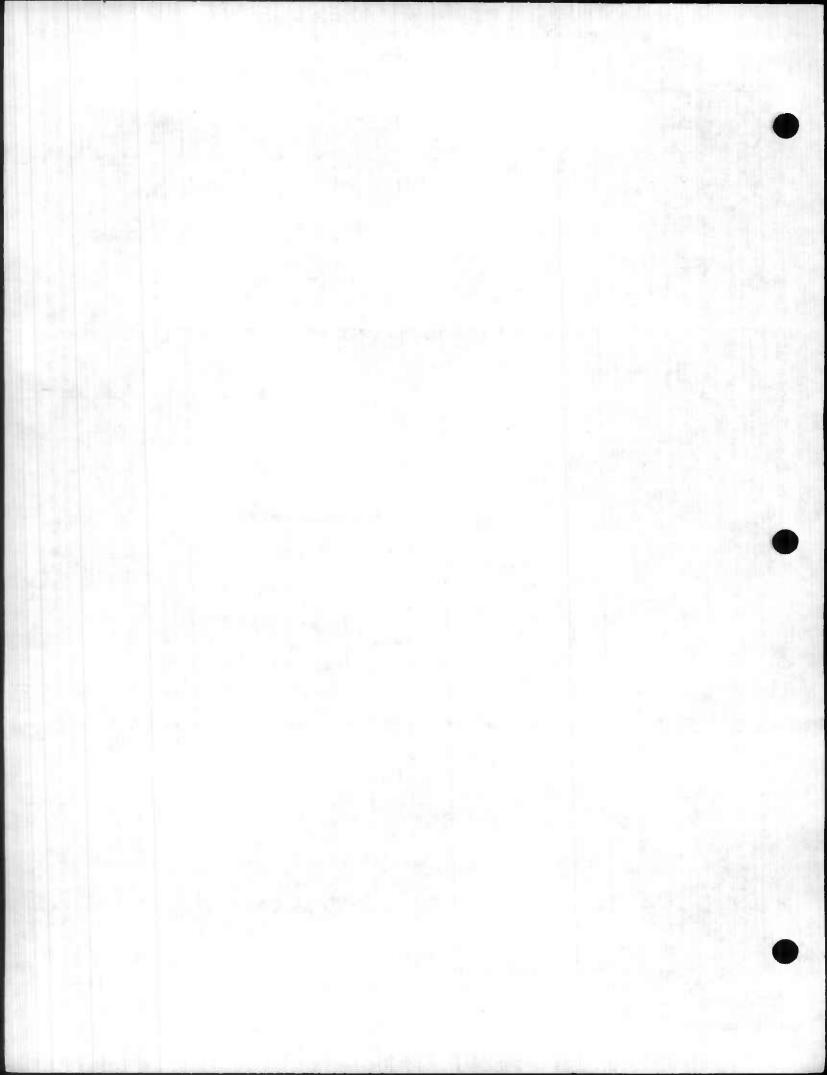
			Cer	tificate of	Death		Reg. No.	0 32	2023			
Dhuaisian	1. Decedent's Nama (First, Middle, La					2. Date of D	eath Day	Year 3	. Time of Death			
Physician /Medical	MILDRED	NIBBLETT				Septemb			12:05 p. n			
Examiner	4a Facility Neme (If not institution, give				,	or Location of Dea	h 4c. Count	y of Death				
	Wicomico Nursing Hon	ne			Salisbu		Wicomi	co				
Funeral		Sax 7. Age (In ye 1 □ M 2 □ F 79	rs. last birthday)	If Under 1 Yea Months Days		Ain. 8. Date of Bi	rth ay, Year)	9. Birthplace Country)	Stete or Fore			
Director	440-20-4406	79 /g	Yrs.			April	9,1921	Oklah	noma			
D .	Usual Residence of Dacedent 10a. Steta 10b. County	100	City. Town or Loc	ration				104	Inside City Lim			
athorite at a second	Maranal Marani		Salisbu						1 🕱 Yes 2 🗆 1			
or 28a-f a be notified	10e. Street and Number			10f. Zip Code			10g. Citizen of					
				218	04	- 10		What Country				
ther death of the there and sine must	11. Maritel Status	12. Was Decedent Evar in	IIS 13 V			/Specify Ves or N	USA	ce - American	Indian			
The Day	1 Never Merried 2 Married	Armed Forces? 1 ☐ Yas 2 ☒ No	10.0	Yes, specify Cu	ban, Mexican, Pi	(Specify Yes or Nuerto Rican, etc.)	Bla	ick, White, etc.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
by B		If Yes, Give Yeer or Detes:	1	☐ Yes 2 No	Specify:		Specia	y: White	5			
7 15 LL			16a, Deced	ent's Usual Occ	pation		16b. Kind of B	Business/Indus	trv			
od within 72 ho ygiens. we than "naturit, the Medical.	(Specify only highest gre	eda completed)	(Give I	kind of work done OO NOT use retir	e during most of ed)	working						
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Elementary/Secondary (0-12)	College (1-4or 5+)	Wait	ress			Resta	aurant				
d other event, Be C)			18. Mother's	Name (First, Middle						
Sed o	William B. Win	ningham			Ann	ie Warre	n					
N DE L	19a. Informent's Neme/Reletionship (Type, Print)	19b. Mailin	g Address (Stree	at and Number of	Rurat Route Numi	per, City or Town	, State, Zip Co	de)			
162	Sam Nibblett/Hu	sband	1502	2 Arbutu	s Dr., S	Salisbury	, MD 218	304				
Ham other	20e. Method of Disposition	206	. Place of Dispos	sition (Name of	h ==1	Date	20c. Location	- City or Town,	State			
N N N N N N N N N N N N N N N N N N N	1 Suriel 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Specif	Removal from State	pringhill	Memoraz Ca		9/25/00	Hebro	on, MD				
# E E	21. Signature of Funerel Service Line			Name and Add		3/23/00	HEDLC	7117 1110				
D A M	3/4 0					l Home Pr	ofession	nal Ass	ociatio			
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between											
	shock, or heart failure. List only	one cause on each line.	eath. Do not ente	er the mode of dy	ring, such as can	diac or respiratory	arrest,	tni	proximate lerval Between nset and Death			
Physician		00	0					O	nset and Death			
/Medical	Immediate Cause (Final disease or condition resulting in condition and allowanced Mulli . Infarct Dementia 10 4											
xaminer	resulting in death)	Due to	(or es a conseq									
in and instransit		Mult	iale	- 01	IA C	echael	Anton	refs 1	0 4/2			
lclan and bunal-transit	Sequentially list conditions,	Due to	for es a consequ	uence of):	0				-			
physician s the buria edical E	that initieted evants resulting in deeth) Lest	Dua to	(or as a consequ	uence of):			1 000					
0 8												
e attendir of for use		d										
rate has been signed by the attending page 2 should be detached for use Completed by Physician/N	Pert II. Other algnificant conditions of	contributing to death but not re	esulting in the un	deriving cause o	iven in Part f.	23b. Did	tobacco use co	ontribute to th	e cause of de			
by the	@ -0:0	71.00	2 .			10	Yes 25 No	3 Probab	ły 4 □ Unkı			
signed by the all the detached for the d	commune	exper	enno	~								
been signed by the should be detached by Physical By P	2/5./2.	(0.0.		0 0	> '	24a. We	s an eutopsy ormed?	24b. Were	autopsy findir ble prior to			
as been 2 shoult	Drypertensen	e Carkios	vas cec	and L	esear	e pen	Offieur	comp of dea	letion of cause			
page 2	(Vac man (2)	t. 7):	/	12	1	10	Yes 2 No	1 🗆 Y				
certificate rector, pag	25. Wes case referred to medical	cery Jusea	ee, c	when	ca.			101	95 ZUINU			
	exeminer?	Hospitel:			thee	Death (Check only						
this crail dire	1 ☐ Yes 2 ☑ No 27. Menner of Death	1 ∐ Inpatient 2		3LI DUA	4 EN MUISE	g Home 5 Res	how injury occu					
in on	1 Maturel 5 ☐ Pending	28a. Dete of Injury (Month, Day Year)	Injury	28c. Inj W		280. Describe	now injury occu	iii ea				
tor: the	2 Accident investigation 3 Suicida 6 Could not b				Yes 2 No	004 4 1'	(0)					
al Director: After the funers led in by the funers Certification:	4 Homicide determined		t home, ferm, stre cify)	et, factory, office	•		(Street and Num wn, State)	iber or Hural H	oute Number,			
S 5 0												
n 24 hou se Funer pletaly fil edical	29a. Certifier 1 Certifying Ph	yalclan: To the best of my k	nowledge, death	occurred et the	time, date and pl	ace, and due to the	cause(s) and m	anner as state	d. a cause(s)			
	one)	end menner steted.				COMING ACTION OFFICE						
To the com	29b. Signature and title of certifier	177-1	2	29c. Licer	nse number		29d. Date sign					
	Veregory h.	Belland	and.	D2	29505		9-20	- 200	00			
	30. Name and address of person who	completed cause of death (It	tem 23a) (Type, F	Print)								
	1	302 Chinaberry			21801							
State	31. Dete filed (Month, Dey, Year)	32. Registrer's Sig		/	4 .							
State	CED 2 2 20		Ø.	ADBO A	21							



State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Reg. No.
	Decedent's Neme (First, Middle, Last)	2	. Dete of Death 3. Time of Deeth
Physician	Sede	MILPAIS S	entember 22 2000 19:15 on
/Medical Examiner	4e Facility Name (If not institution, give street and number)	4b. City, Town, or Local	-11 -10 -10 -10 -10
Examiner	The Topus Harling Has	2:1/2/ By/1:	City
Europa)	5. Sociel Security Number 6/Sex 7. Age (In ye). Is	ast birthday) If Under 1 Year If Under 24 Hrs. 8	Date of Birth 9. Birthplace (State or Foreign
Funeral Director	216-27-1367 1DM 2CXF 14	. Months Devs Hours Min.	(Month, Pay, Year) OCT. 5,1985 WASHINGTON, DC
p .	Usual Residence of Decedent		1011-11-02-11-2
vith the Meryland or 28s-1 show be notified at		Town or Location ON HILL	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the Na or 28a-1	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
		20745	USA
fter death v	11. Marital Status 12. Wes Decedent Ever in U,S	5. 13. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- 14. Race - American Indian,
by by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give A Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: BLACK
led within 72 hours at yglene. The work had not be the work of the	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business/Industry
d within glene.	Elementery/Secondery (0-12) College (1-4or 5+)	life. DO NOT use retired)	
d will be	10TH	STUDENT	N/A
TA SE		18. Mother's Neme (F	First, Middle, Maiden Surneme)
Menta	DAVID HARTUNG		M. OWENS
ols should be made	19a. Informent's Neme/Relationship (Type, Print) (MOTHER		
alth a	TOWANA M. OWENS-LAWRENCE	1307 DUNWOODY AVE,	DXON HILL, MD. 20745
of He other	Ce	ace of Disposition (Neme of metery, crematory or other place)	Date 20c. Location - City or Town, State
mit. Pages 1 pertment of He portant: If Item y Injury or oth	1 Li Buriel 2 La Cremetion 3 Li Removal from State	TROPOLITAN CREMATORYS	9/28/00 ALEX. VA
permit. Pa Depertmen Important: any Injury	21. Signature of Funeral Service Licensee	22. Name end Address of Facility	
Depending of the poor of the p	100 mm	AUSTIN ROYSTER FU	
	23a Part1. Epter the disease, or complications had eaused the death.	3821 14TH ST. N.V	
DI LI	shock or heart feilure. List only one cause on each line.	botton differ the mode of dying, each of cardial of the	Interval Between Onset and Death
Physician /Medical	Immediate Cause (Finel	EI	2 /2/10
Examiner	disease or condition resulting in death)	Edema	3 Lays
e leading		as a consequence of):	3 Davie
axecuted in and itel-transit	of TNOXIA, H	as consequence of):	m/a stuys
be axecuted icien and burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ase consequence or):	6 / T. 111: 3 Xauce
physicien the burie		nest Heten LNdotraci	near Intubation step
	resulting in death) Last	nt Fai Lune Sevene b	Aporte Stransis Moinths
attend for us	V		
the dry the ached	Pert If. Other significant conditions contributing to deeth but not result	ting in the underlying cause given in Pert I.	23b. Did tobacco use contribute to the cause of death?
as that the igned by be datace			1 Yes 2 No 3 Probably 4 Unknown
requiras meen sign hould be			24a. Wes an autopsy 24b. Were eutopsy findings
			performed? eveileble prior to completion of cause
has by ga 2 s			of death?
The la			1 ☐ Yes 2 No 1 ☐ Yes 2 No
Physician: The this certificate ral director, peg	25. Wes case referred to medical	26. Place of Deeth (Check only one)
this ceral dire	Hospital: C	ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 Residence 6 Other (Specify)
Affecth Affecth funeral		28b. Time of 28c. Injury et 28 Work?	d. Describe how injury occurred
Attending r death. ector: After by the fune	1 Naturel 5 Pending (Month, Dey Year) 2 Accident investigation	M 1 Yes 2 No	
ra or Attending P rs after death. In Director: After t led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pleca of Injury - At hor building, etc. (Specify)		f. Location (Street and Number or Rural Route Number, City or Town, State)
de sate	Duranty, etc. (apocny)		ony of volume, orange,
To the Hospital or Attend within 24 hours after death To the Funeral Director: completaly filled in by the Medical Certifical	(Check only 2 Medical Examiner: On the basis of examinetic	rledge, deeth occurred et the time, date end placa, end on and/or investigation, in my opinion, deeth occurred	
hin 2 hin 2 Med	one) end menner steted.	7	COL Data sissed Misself Con Vessi
To the comple	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Mold wind Ja	HEMD KES-DOG	O September 25,2000
	30. Name and andress of person who completed cause of deetN (Item	23a) (Type, Print)	O September 25,2000 one, Maryland 21287
		Wolfe Street Biltimo	ore, (naryland 2128)
State	31. Date filed (Month, Day, Year) 32. Registrer's Signet		
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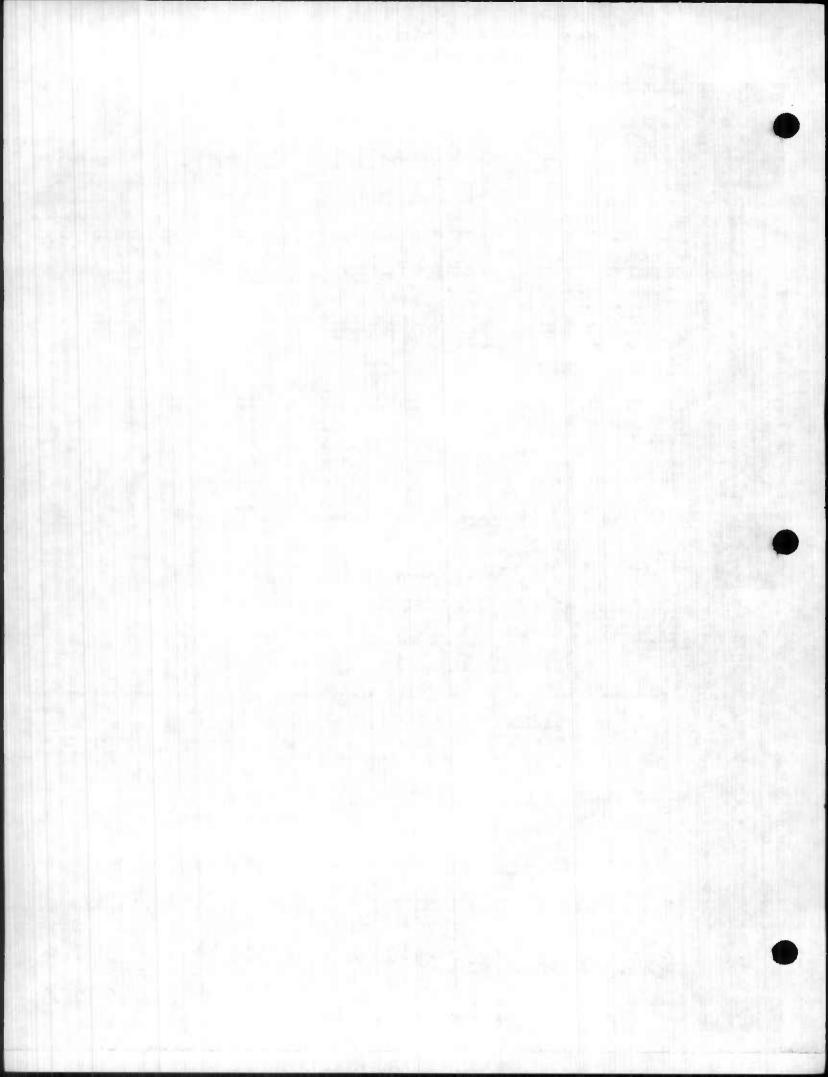
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 22, 2000 11:35PM **Physician** Roderick John O'Neil /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 1677 Pleasant Plains Road Annapolis Anne Arundel 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 69 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 30, 1930 9. Birthplace (State or Foreign Florida 5. Social Security Number **Funeral** Deys Hours 263-60-3644 Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or forms 23s or 28s-f show the Medical Examiner must be mothled at 1 Yes 2 No MD Anne Arundel Annapolis Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1677 Pleasant Plains Road 21401 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U,S.
Argued Forces?
1 ☐ Yes 2 ☐ No
If Yes, Giva
Year or Dates: 53-57 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, atc. 11. Marital Status 1 Never Married 2 Merried 1 Yes 2 No Specify: 3altimore, Maryland 21215-0020 by Specify te 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Self-employed Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Financial Consultant 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surname) permit. Peges 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event obtes. Thomas Francis O'Neil Mary Pearl Agnew 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Roderick O'Neil /Son 1677 Pleasant Plains Rd, Annapolis, MD 21401 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Placa of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State Sep 27 2000 Beltsville, MD Chesapeake Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Liqui ²²Rapp Funeral Cremation Services 933 Gist Avenue Silver Spring, MD 23a. Part1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or hear failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Finel diseasa or condition rasulting in death) /Medical Head and Neck Cancer 21months Examiner Due to (or as a consequenca ot) Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequenca of). Bnd Box 68760. use as the Due to (or as a consequence of) Pot P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown signed by of Vital Records, Aq 8 24b. Wera autopsy tindings availabla prior to completion of cause of daath? funeral director, page 2 should Be Completed 24a. Was an autopsy certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case refarred to medical 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 Yes 2 No 5 Residence 6 Other (Specify) Medical Certification: To 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Matural 5 Pending investigation after death. 2 No 1 Yes 2 Accident the 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 29c. License number 6+ completed cause of deeth (Item 23a) (Type, Print) Nama and address of person who 600 Kussen 100 31. Data filed (Month, Day, Year) 32. Registrar's Signature State 27 2000

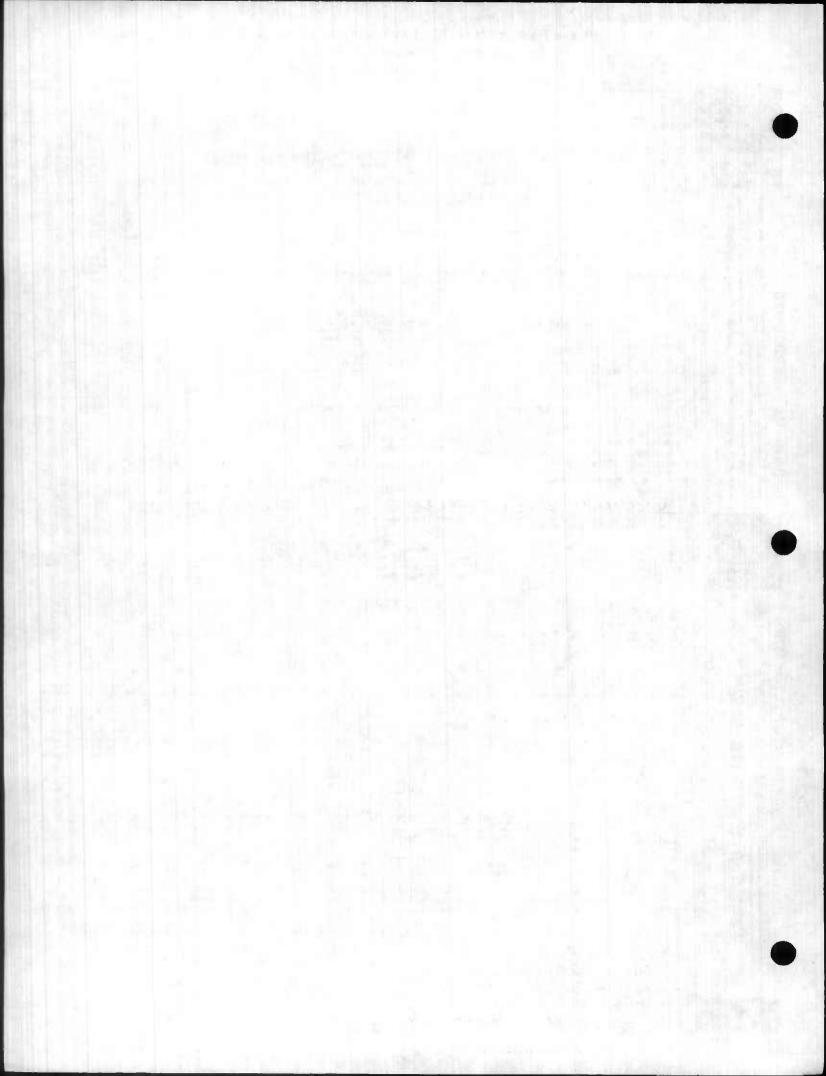
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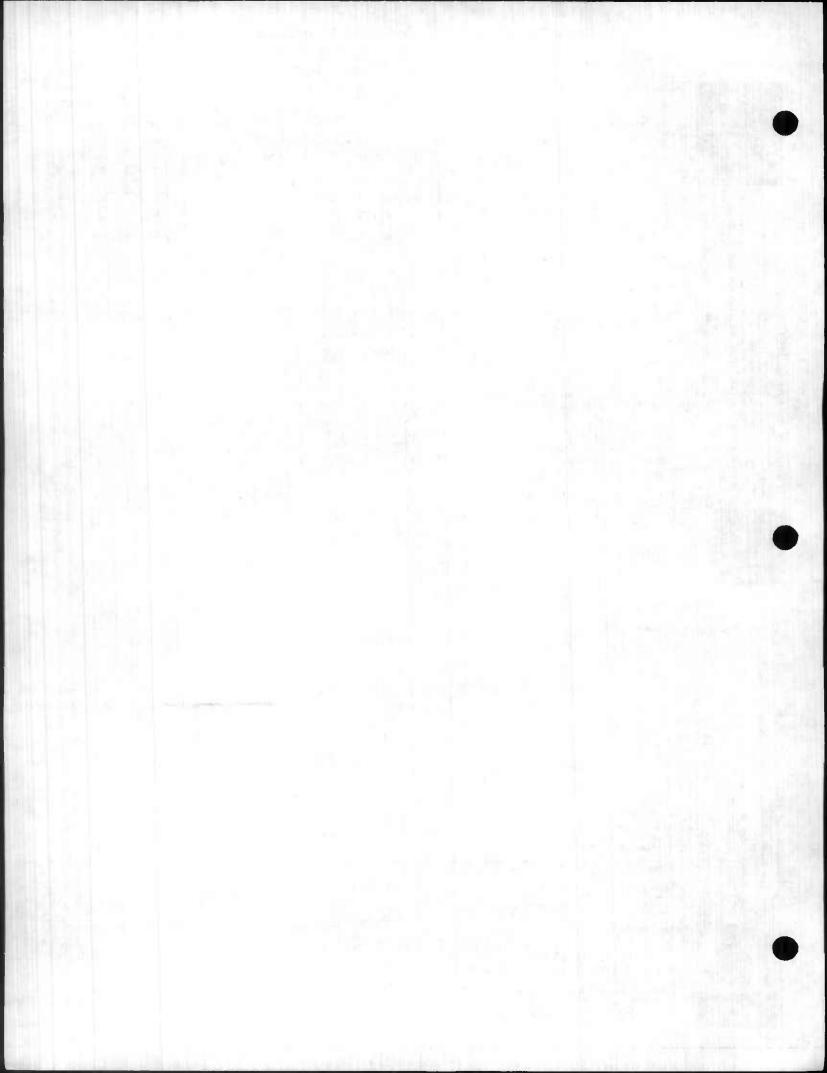
				Certificate	of Death		Reg. No.		
	1. Decedent's Neme (First, Midd	die, Last)				2. Date of De		Veer	3. Time of Death
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/Medical Examiner	to English Stamp (If not ingtibution)			0.102.02.	4b. City, Town, o	r Location of Deel			19:05 AM
Examiner	Genesis Eld			00	East	on	-	Talbo	o.t
	5. Sociel Security Number	6. Sex	7. Age (In yrs. last			S. 8. Date of Bi	rth		lece (Stete or Foreig
Funeral Director	186-10-2063	1 € M 2 □ F	80	Yrs. Months	Days Hours Mir	8. Date of Bi (Month, Di Nov. C	1919	Pen	na .
Director	Usuel Residence of Decedent					1-1-1-1	,		
5 Eu	10e. Stete 10b. Count	y	10c. City, To	own or Location				1	0d. Inside City Limit
Mary led an	Maryland Tall	hot	St	Michaels					1 ☐ Yes 2 ➡ N
or 28a-fa be notified	10e. Street and Number	501		10f. Zip (Code		10g. Citizen of 1	Whet Coun	ntry?
		Terrace			1663		U.S.A		
her death v r hema 23 siner must	44 Marital States		cedent Ever in U.S.		ent of Hispanic Origin?	Specify Ves or N		e - Americ	an Indian
er o Ber Der	11. Meritel Status 1 Never Merried Ma	Armed F	Forces? WWII	If Yes, speci	y Cuban, Mexican, Pue	rto Rican, etc.)	Blee	ck, White,	etc.
dr. or		If Yes C	Sive	1 ☐ Yes 2	No Specify:		Specify	. Whi	te
				De Desentantis Naval	Occupation		10h Kind of D	vein needle	desates
ed within 72 ho ygiens. wer than "natur it, the Medical.	15. Decede (Specify only high	ent's Education Lest grade completed		Give kind of work	done during most of we retired)	orking	16b. Kind of B	usiness/inc	dustry
6 2 2 3	Elementery/Secondery (0-12)	College	(1-4or 5+)				Famo	i C	
C Hara	12			Self Emplo					ontractor
Be wen	17. Father's Neme (First, Middle					eme (First, Middle		ne)	
The stand		se			Edith	Constar	tine		
de de la	19a. Informant's Name/Relation	nship (Type, Print)	1	9b. Mailing Address	Street end Number or I	Ru <i>ral Route Num</i> l	per, City or Town,	Stete, Zip	Code)
Dally The	Mary Ellen O	lcese 1	Daughter	7132 Pea l	Neck Rd. St	. Michae	els, Mar	yland	21663
L Hom other	20a. Method of Disposition		20b. Place	of Disposition (Nem	e of	Date	20c. Location	City or To	own, State
90 H 3	1 Buriel 2 Cremation 4 Donetlon 5 Other (n State	•		25 2000	Dorron	Dol	OWO MO
it. Pages 1 intrament of He relaint: If liber Injury or oth	21. Signeture of Funeral Service		Capit		ory Sept.			, Del	aware
E STATE OF THE STA	21. Signeture di Funeral Service	e Licerisee	0	Harris	Address of Fecility on E. Leona	rd Funer	al Home		
. 402.0	Danish	16.00	ernala	312 S.	Talbot St.	St. Mic	haels, I	Maryl	and 21663
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Physician								1	Onset and Deeth
/Medical	Immediate Ceuse (Final disease or condition		End	15+0	a De	2011	a		540V
Examiner	resulting in death)	ā	Duata for as	0 0000000000000000000000000000000000000	ge Der	~~~	0	1	1
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ficate be executed physician and is the bunal-transit		b	Due to for so						
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icate be executed physician and s the bunial-transit	thet initieted events resulting in death) Last		Due to (or es	e consequence of):					
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the a the a hed f	Part If. Other eignificant condit	tions contributing to	death but not resultin	g in the underlying ca	use given in Pert I.	23b. Dic	tobacco usa co	ntribute to	o the causs of deat
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es than be de be de be de	" Helper Ch	au u	your						
clan: The law requires the entificate has been signed actor, page 2 should be completed by	2 711	/				24a. We	s en autopsy	24b. W	ere eutopsy finding ailable prior to
v require	FIIN					pen	ormed?	CO	mpletion of cause death?
has pe 2	1 henre	100					-06		
	agres	2000 -				10	Yes 212 No	11	☐Yas 2☐ No
Physician: this certific ral director,	25. Wes case referred to medic examiner?					eeth (Check only	one)		
Joseph Joseph	1 Yes 2 No			Outpetient 3 DO		Home 5 Res	sidence 6 Ott	ner (Specil	(y)
ding Ph. After the funeral	27. Menner of Death	28e. Det	e of Injury onth, Dey Year) 28	Time of 28 Injury	lc. Injury at Work?	28d. Describe	how Injury occur	rred	
Attending or death. Sctor: After by the fune	2 Accident inves	tigetion		M	1 ☐ Yes 2 ☐ No				
or Attending I after death. Director: After I in by the fune ertification	3 Suicide 6 Could 4 Homicide deter	minad Zoe, Ple	ce of Injury - At home Iding, etc. (Specify)	ferm, street, factory	office	28f. Location	(Street end Num.	ber or Run	al Route Number,
din din	Tomicide	bun	uling, etc. (Specify)			Only or 1	,,, 0.0.0,		
To the Hospital or Attending Physis within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director. Medical Certification: To	29a. Certifier 1 Certify	ing Physician: To th	ne best of my knowled	lge, deeth occurred e	t the time, date end ple	ce, and due to the	e ceuse(s) end m	enner es s	steted.
Fur Fur dic	(Check only 2 Medica	I Examiner: On the	basis of examination	and/or Investigetion,	in my opinion, deeth oc	curred at the time	, date end place,	end due t	o the cause(s)
within To the comple	29b. Signature and title of costs	ior /		290	License number		29d. Date signe	ed, (Month,	Dey, Year)
7.37.8	1 MAGE	MAI		U	42587	,	0/50	1	2
	1000	000		17	1000		7/03	100	0
	30. Name end eddress of perso	n who completed ca	use of deeth (Item 23	a) (Type, Print)	(1)	ra +	41- 4		
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State	31. Dete filed (Month, Dey, Yea	r) 3e.	Registrer's Signeture	/ /					
Registrar	CED 9 6	2000	mere.	D. Sop	Ms/				
	SEL Y U	LUUU		-					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death **Physician** 25, 2000 Patricia Putterman Sept. 11:15pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 101 Odendhal Ave. #604 Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 264-34-8000 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplece (State or Foreign **Funeral** Months Days Hours Min 1 M 2 X F Yrs. Mar. 24,1927 73 Michigan Director Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at Md. Gaithersburg Montgomery 1 No Yes 2 No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? WITH Items 23a 101 Odendhal Ave. #604 20877 United States permit. Peges 1 and 2 should be filed within 72 hours efter death Department of Health and Mental Hygiene. Important: If New 27 Is marked other than "natural", or thema 23 any Injury or other traumatic event, the Mental Example many Injury or other traumatic event, the Mental Example many Injury or other traumatic event, the Mental Example many Injury or other traumatic event, the Mental Example many Injury or other traumatic event, the Mental Example many Injury or other traumatic events. 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: NO Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Administrator Credit 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Minard Enright Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Janet Jernigan (Daughter) 20554 Afternoon Lane Germantown, Md. 20874 Baltimore, 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method ot Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Sept.26, Alexandria, Va. Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) any Injury 2000 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses 10 East Deer Park Dr. Gaithersburg, Md. 20877 witer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in deeth) /Medical Apnea 1 Hour **Examiner** Due to (or as a consequence ot): Physician/Medical Examiner Metastatic Lung Cancer 2 Years use as the burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): and Box 68760. the attending physician Due to (or as a consequence ot): P.O. this certificate hes been signed by the religious director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 | Probably 4 | Unknown Division of Vital Records. à Completed 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to complation of ceusa of deeth? 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No l or Attending Physician: after death. funerel director, Be 25. Was cese reterred to medical 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 10 1 Yes 2K No 28c. Injury at Work? 28d. Describe how injury occurred edical Certification: 27. Manner of Death After 5 Pending investigation 1 Neturel Injury 1 ☐ Yes 2 ☐ No eral Director: A filled in by the fi 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 10 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and manner stated. 29e. Certifier complately 290. Signature tind title of payfile 29c. License number 29d. Date signed (Month, Day, Year) RES-000 September 26, 2000 nd address of person who completed causa of death (Item 23a) (Type, Print) Paul Thombi M.D. 8901 Wisconsin Ave. Bethesda, Md. 20889 31. Date filed (Month, Day, Year) SEP 2 7 32. Régistrar's Signature State senera souls Registrar

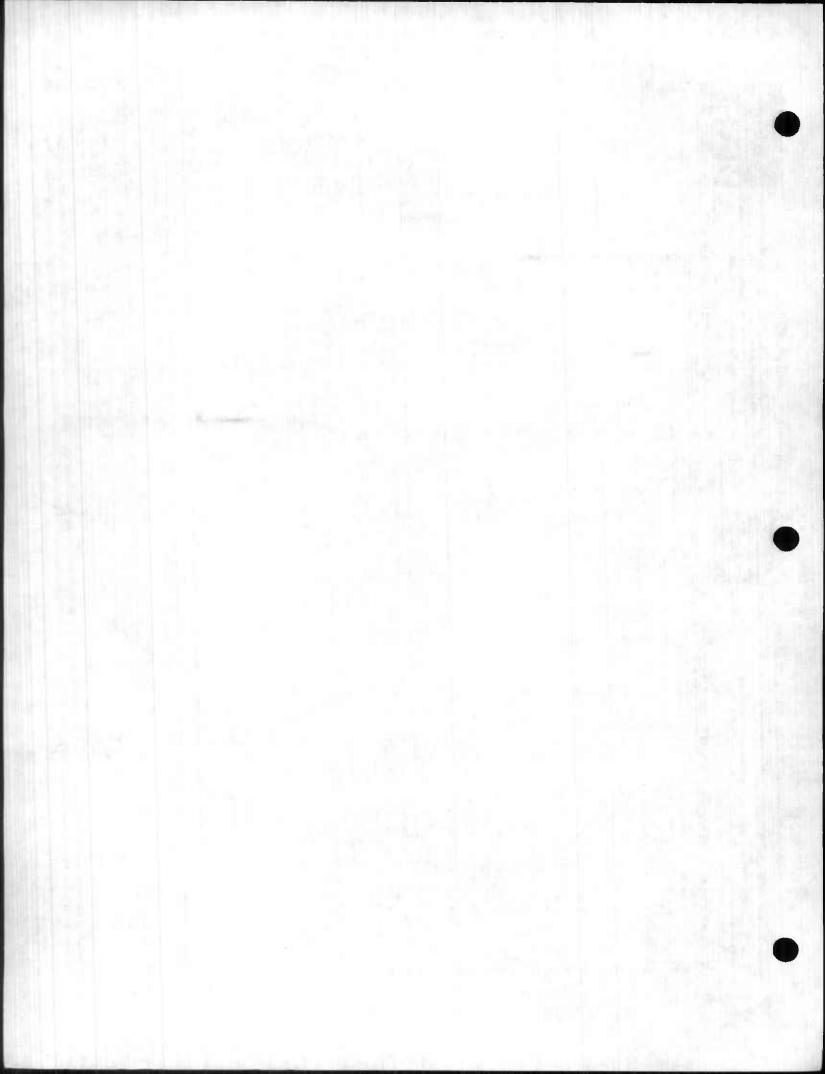


State of Maryland / Department of Health and Mental

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						Ce	rtificate o	f Death		R	eg. No.		
		1. Decedent's Nan	ne (First, Middle	, Last)		4 11				2. Date of Dea Month	th Day	Year	3. Time of Death
	Physician /Medical	Nel1	ie E. P	olutchko						Septemb	er 20,	2000	8:00 PM
	/Medical Examiner	4a Facility Name	(If not Institution,	, give street and no	um <i>ber</i>)			4b. City, To	wn, or Lo	cation of Death	4c. Count		
	Examiner	Subu	rban Ho	spital				Beth	esda		Mont	gome	cy
- 88	Funeral	5. Social Security		6. Sex	7. Aga (In yrs	s. last birthday)	If Under 1 Ye			8. Date of Birth	1	9. Birthp	elece (State or Foreign
	Director	184-38-9	9430	1□M 2以F	87	Yrs.	Months Day	/s Hours	Min.	Dec. 6,	1912		sylvania
100		Usual Residence of Decedent											-) =
Aano	No to	10a. Stata	10b. County		10c. C	ity, Town or Lo	ocation		6-11			1	Od. Inside City Limits
Man	1 of	Maryland	Montgo	omerv	Pot	tomac							1 ☐ Yes 2 💢 No
를	790	10e. Street and Nu					10f. Zip Code	9	190	1	log. Citizen of	Whet Cour	ntry?
death with the Maryland	r items 23s or 28s-fs oner must be nother Funeral Director	10714 Pot	romae To	nnic Lan			2085	4		0.5	United	Stat	res
tae	78 2 10 10 10 10 10 10 10 10 10 10 10 10 10 1	11. Marital Status	Jomac Te	12. Was Dec	cedent Ever in	U,S. 13.	Was Decedent o		gin? (Spe	ecify Yes or No-		ca - Americ	
9	E P	1 Naver Mar	ried 2 Marri	Armed F ed 1 ☐ Yes	2 🔯 No				n, Puerto	Rican, etc.)	Bla	ck, White,	
020 urs a	, o	3 🕅 Widowed	4 Divorced	If Yes, G Year or I	liva T Dates:		1□ Yes 2☑N	lo Specify:			Specil	y: Wh:	ite
5-0020	ygiene. Nor than *natural', It, tre Medical Ex. Completed by	10	15. Decedent		**	16a. Dece	dent's Usual Occ	cupation			16b. Kind of B	usiness/In	dustry
-		Elementery/Sec		t grade completed	(1-4or 5+)	- (Give	kind of work dor DO NOT use ret	ne during most ired)	t of work	ing			
21.2 J. vit	omeigned in the	8	ondary (0-12)	College	(1-40/ 5+)	C1	erk			10.01	Pharma	асу	
D &	d other event,	17. Father's Name	(First, Middle, L	Last)				18. Mothe	er's Nama	(First, Middla,	Maiden Sumai	ne)	
d b	Mente arked To B	Antho	ny Maze	tis				Mar	y Wi	ckham			
Maryland 21215-0020	DE L	19a. Informant's N				19b. Maili	ng Address (Stre		-		r, City or Town	, State, Zip	Code)
	27 is	Robert F	olutchk	o/Son		9313	Belmart	Road.	Pot	omac. Ma	rvland	2085	4
ē, -	Hem of the	20a. Method of Dis			20b.	Placa of Dispo	sition (Name of			Date	20c. Location		
no ege	y or		Cremation 5 Other (Sp	3 Removal from	State		Annunciat			ept. 26	Pringle,	Permey	ซไซลกเล
5. M. EBaltimore, permit. Peges 1 at	Department of Heelth end Mentel Hygiene. Important: if item 27 is merked other than any injury or other treumatic event, the Mance. To Be Comp	21. Signature of F			2				-				
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2 di ta	detac detac	Pneumoni	Pneumonia, Urosepsis, Atrial Fibrillation, Osteoporosis									3 N Pro	bably 4 Unknown
JAKO, WO I Records, P.O The lew requires thet the										24a. Was a	n autoney	24h W	ere eutopsy findings
Ko, ecords	been s should	Polymyal	gia, Rh	eumatism	, Seizu	res du	e to cer	ebrova	scul	ar perfor	med?	64	alleble prior to impletion of cause
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	Cor Cor	accident					1.4			1 🗆 Y	es 2 🔯 No	1[☐ Yes 2☐ No
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of Vita	in F	1 Yes 2 7	~		Inpatient 2		III JU DON			me 5 Resid			(y)
	ther	27. Manner of Dea 1 X Natural	5 Panding		of Injury nth, Dey Year)	28b. Time of Injury		njury at Vork?		28d. Describe h	ow injury occu	rred	
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Pol.	irect n by	4 Homicide	determi	ned 200. Flat	ca of Injury - At I ding, etc. (Spec	home, farm, st city)	reet, factory, offic	ca		City or Tow		per or Hun	al Route Number,
D ja	Se led												
Hospitai	une une ely fii	29a. Certifier (Check only		Physician: To the Examiner: On the I									
2	within 24 hours efter deatl To the Funeral Director: completely filled in by the Medical Certificat	one)			nnar stated.								
To the		29b. Signatura and	d title of certifier	1	1			anse number	11	4	29d. Date sign		
	10			1			2	1292,	, (The wall	ar c	1, 2002
		30. Name and add	ress of person	the completed cau	use of death (Ite	em 23a) (Type,	Print)				1		
		Jose Qui	ros, M.	D. 4343	Montgo	mery A	venue, E	Bethesd	a, M	aryland	20814		
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	Registrar	- 3	SEP 25	2000	Pacu-ar	10.	populario	B					

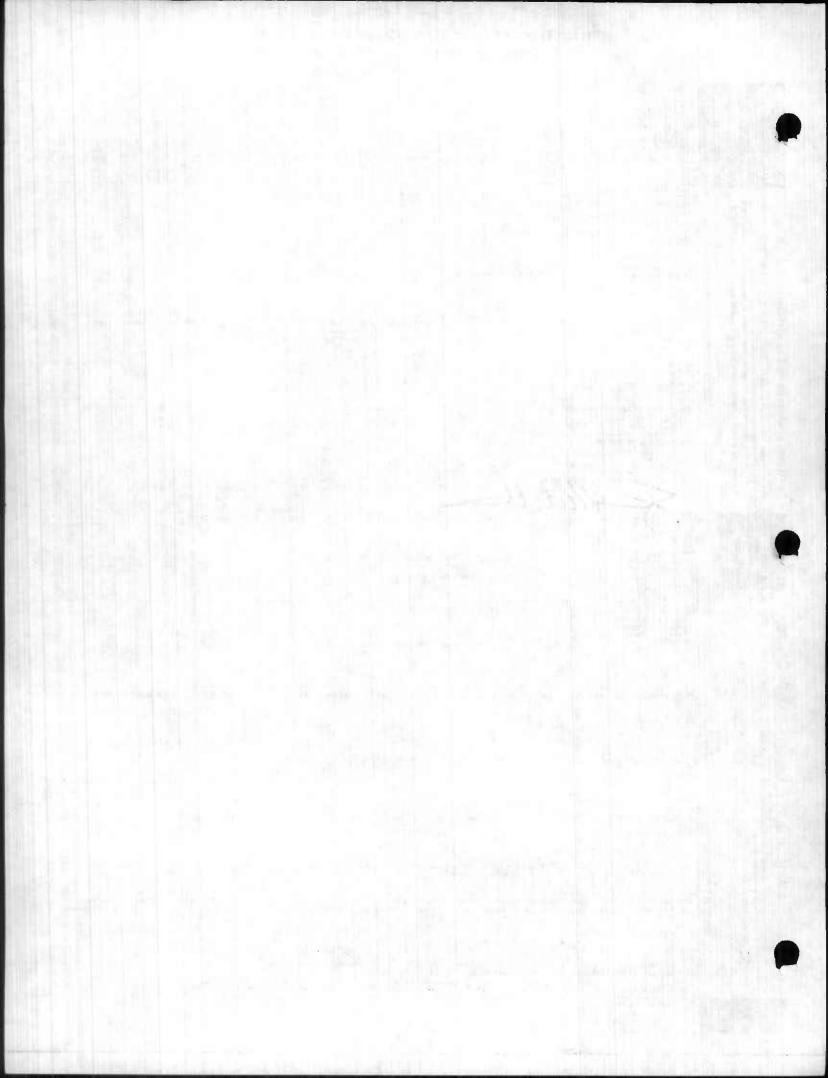
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

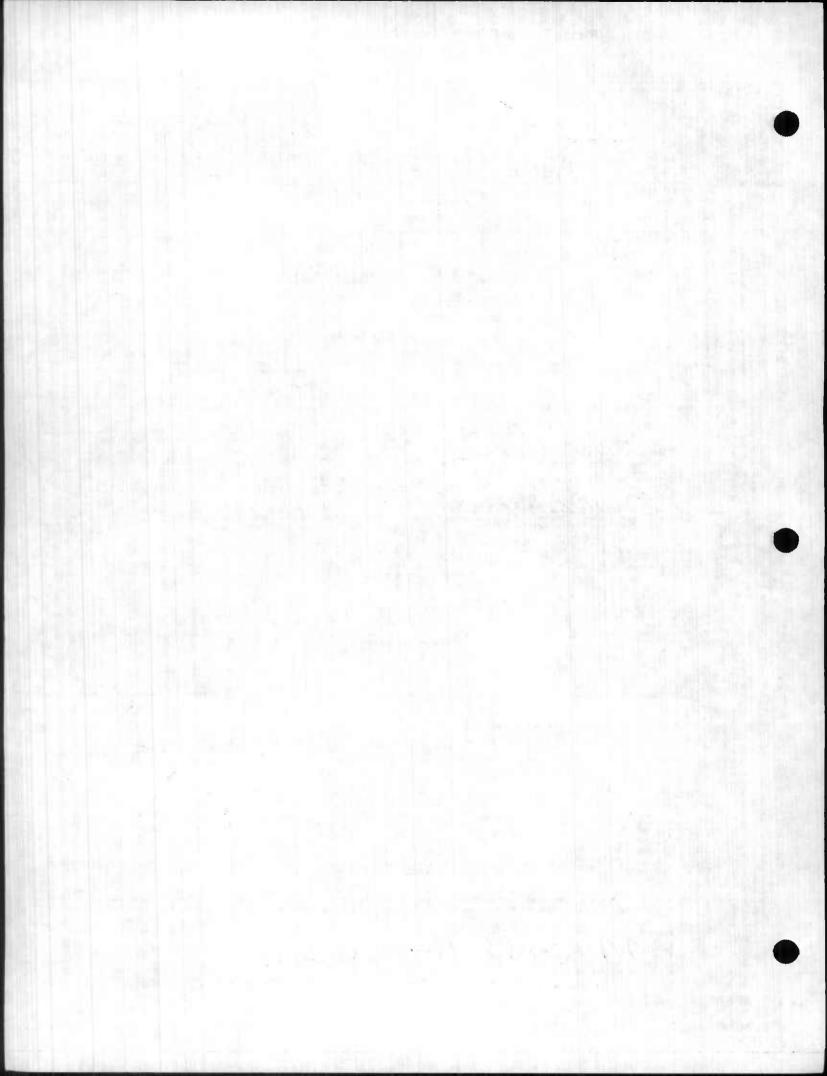
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ral lor	5. Social Security I		. Sax 1 □ M 2 X F	7. Aga (In yrs	/ Vrs.	Months	Days	If Undar Hours	Min.	8. Data of Bir (Month, Da April l	th Year) 1, 1933	9. Birthp	laca (Stata or itry) WV	Foreign
tor	10a. Stata	10b. County Montgo	mery		ity, Town or Lo							1	0d. Inside Cit	1000
II Director	10e. Street and Nu	ul Drive					o Coda				10g. Citizan of V	Vhat Coun	itry?	
	11. Marital Status 1 Navar Marital Status	rled 2 Married	Armed F	2 X No		Was Dece If Yas, spe 1 Yas	ocify Cub	an, Maxicar	gin? (Sp n, Puarto	ecity Yas or No Ricen, atc.)	Blac	e - Amaric k, Whita, whi		
		15. Decedant's cify only highast gondary (0-12)	grada complated,) (1-4or 5+)	16a. Dace (Giva lifa.	dant's Usu kind of we DO NOT u	ork dona	during mos	t of work	ing	16b. Kind of Bu	isinass/Ind	dustry	
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	20a. Mathod of Dis	Cramation 3	☐Removal from	20b.	Place of Disponentary, cran	osition (Na matory or	ma of othar pla	ca)	1	Date 0/29/00	D 20851 20c. Location - Beltsv:	City or To		
	21. Signatura of F	5 ☐ Other (Speunaral Service Lic		OI.	Ra	2. Name a	nd Addra	ass of Facili	Cr	emation	Service	s	910	
edical Examiner	23a Part1. Inter shock or had Immediata Causa disaasa or conditi- rasulting in daath)	(Final		RONIC O	ath. Do not an	TIVE	da of dyi	ng, such as	cardiac	or raspiratory a	rrast,	1	Approximate Interval Betwoen and Conset and	ween Death
	Sequantially list of any, laeding to it cause. Enter Und Cause (Disease o that initiated event rasulting in death)	onditions, mmadiata arlying r injury is Last	c		or as a consec								1	
	Part II. Other signi												tribute to the cause of death 3X Probably 4 Unknow	
in more dimen											an autopsy ormed?	017	ara autopsy fi ailabla prior to mpletion of c deeth?	0
	25. Was cesa rafa	rred to medicet						26. Place	a of Daa	1 □		10	∃Yas 2XX	No
OI. 10 DG	axaminar? 1 Yas 2 2 27. Mannar of Dea 1 Netural	th 5 Panding	28a. Data (Moi	Inpatient 2[of Injury oth, Day Year)	28b. Tima o	of	28c. Inju				dence 6 Oth		(y)	
cer micanon.	2 Accidant 3 Suicide 4 Homicida	invastigat 6 Could not determine	be 28a. Plac	e of fnjury - At lifting, etc. (Spec	home, farm, st	M reet, facto					Street and Numb wn, State)	per or Rura	al Routa Num	ber,
Medical	29a. Cartifier (Check only one)		ammfner: On that								ceuse(s) and me data and place,)
	29b. Signatura and	titla of certifiar	W.			29		sa number 055200			29d. Data signed (Month, Day, Year) SEPTEMBER 28, 2000			
	30. Nama and add		M.D.,		DOCTORS		, GE	RMANT	OWN,	MD 20	874			



State of Maryland / Department of Health and Mental Hygiene 0 32030

				Certificat	e of	Death			Reg. No.	0	22000	
BL -22-22-	1. Decedent's Neme (First, Middle,							2. Dete of De		Year	3. Time of Deat	
Physician /Medical	John Donal	d Penab	are					Sept.	25, 2	000	12:55p.	
Examiner	4a Facility Name (If not institution, 9224 St. Andre)					cation of Deat Park			eorge's	
Funeral Director	5. Sociel Security Number 087–22–9865	Sex 7. A	ge (In <i>yrs. last birtl</i> 67 Y	Months	Deys	If Undar Hours	24 Hrs. Min.	8. Date of Bir (Month, Di Sept • 2	7,1932	9. Birthp Court New	lace (Steta or Fore try) York	
Maryland f show led.at	Usuel Residence of Decedent 10a. State 10b. County Maryland Prince	George's	10c. City, Town	or Location ge Park						1	0d. Inside City Lim	
ar death with the Maryla heres 23a or 28e-f shor her mat be notified at unneral Director	10e. Street and Number 9224 St. Andre	ws Place			0740)			10g. Citizen of V			
er. or	11. Merital Status 1 Nevar Married 2 Married 3 Wildowed 4 Divorced		?	13. Was Dece If Yas, spe		dispanic Or en, Maxica Specify:		ecify Yas or No Ricen, etc.)	Bia	ce - Americ ck, Whita, y: Wh	atc.	
ed within 72 ho opjers. wer than "naturn it, the Medical.]	15. Decedent's (Specify only highest of Elementery/Secondery (0-12)	Education grade completed) College (1-4or		Decedent's Usu 'Give kind of wo life. DO NOT u	ei Occup ork done sa retire	oetion during mos d)	st of worki	ng	16b. Kind of B	usiness/Ind	lustry	
Ilw Diens	12	College (1-40)		gineer				- 12	Textron	Home	Light	
STATE OF	17. Fethar's Nama (First, Middla, La	st)				18. Moth	er's Neme	(First, Middle	, Maiden Sumen	ne)		
marked marked marke To E	Anthony		Pe	enabare		Ju1	ia				Fusco	
2 4 2 5	19a. Informant's Name/Relationship Irene Penabare	(Type, Pnint) (Wife)		Meiting Address			er or Rure	I Route Numb	er, City or Town,	Stete, Zip	Code)	
ages 1 and nt of Health it if from 27 or other tr	20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery, crematory or other place) 20b. Plece of Disposition (Neme of cametery, crematory or other place) 3 Removal from State 4 Donation 5 Other (Specify) St. Mary's Cemetery Sept. 29, 2000 Rye Brook											
certificate be executed digital physician and continued as the bunkel-transit as the bunkel-transit and the bunke-transit and the bunke-transit and the bunke-transit and the bunk-transit and the bunk	23a. Pert1. Enturn disease, or co shock, or near teilure. List on immediete Ceuse (Finet disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immedieta cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last		d the death. Do not the death.	on enter the modern th	cer	ng, such es	cerdiac c	or respiretory s	prest,	1	Approximete Interval Between Onset end Death 3 months	
ires that the death certifical signed by the attending placed for use as the be detached for use as the by Physician/Med	Pert II. Other significant conditions	d	but not rasulting in	the underlying	ceuse gi	ven in Pert	1.				o the cause of dea	
The law requires that sate has been signed by page 2 should be determined.								24a. Was	Yes 2□ No s an autopsy ormed?	av	bably 4 Unkn ere autopsy finding eileble prior to mpletion of causa deeth?	
centificate he rector, page								10	Yes 20 No	10	Yes 20 No	
certificate rector, pag	25. Wes cese referred to medical examinar?	Title 1-35-1					e of Deeth	(Check only	one)			
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To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funera Medical Certification:	3 Suicide 6 Could not determine	28e. Piece of in	njury - At home, fen tc. (Specify)	m, street, fector	y, office				(Street end Numi wn, Stete)	ber or Rure	al Route Number,	
To the Hospital within 24 hours a To the Funeral I completely filled		Physician: To the best aminer: On the basis of end menner's	of examinetion end									
Within To the complex Me	29b. Signeture end title of certifier	0 (29	c. Lican:	sa number			29d. Date signe	ed (Month,	Dey, Year)	
20	11119	in all	MA	+	0	351	74		Septemb	er 2	5, 2000	
	30. Name and address of person wh Marcia Will, M.D				ive,	#205	Gre	enbelt	, Maryla	and 20	0770	
State Registrar	31. Dete filed (Month, Dey, Year) SEP 28		rer's Signeture	9. de	onk	1						



		- 7	Cen	uncat	e or i	Death		las	Reg. No.			
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SIMON PEARLMAN										000		20:09
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	GM 20F	83	Yrs.	Months	Deys	Hours	Min.	8. Dete of E		16	Cour	itry)
Usuel Residence of Decedent								NOV 1	0, 19	10	TATTAA	TOTAL
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MD MONTGOM	ERY	SI	LVER	SPR	ING							1X Yas 2□
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1 Nevar Merried 2 Married	17 Yes 2□		17.5	Yes		Specify.		rican, ac.,			WH	ITE
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		□ 163	١١٥ نورع	Specify.				Specify		
15. Decedent's Ed (Specify only highest gra		1	6e. Decede	and of wo	ork done	during mos	st of work	ing	16b. Ki	ind of Bu	usiness/In	dustry
Elementary/Secondary (0-12)	College (1-4o		life. D	O NOT u	ise retired	1)			GF:OC	עסקי		
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SAMUEL PEARLMAN										-	0	0.11
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BESS PEARLMAN/WI	LFE		e of Dispos				"-					
0a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐	Removal from Stet	ceme	etery, crem	atory or o	othar pled		. !	SEPT 24		Cation -	City or FC	own, Stete
4 Donetion 5 Other (Specif)	X /	MOUN	T LEB	BANON		ETEK:	Y I		7.07	OT DIE	TT NA	ARYLAND
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To the Hospital or Attending Physician: The law requires that the death certificate be associted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely illed in by the funeral director, page 2 should be detached for use as the buriar-transit

Division of Vital Records, P.O. Box 68760,

Physicia /Medic Examin

Funeral Director

permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Manylend Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or hems 23s or 28=4 show emportant: If them 27 is marked other than "natural", or hems 23s or 28=4 show emportant in july 90 or other traumatic event, the Wideral Energy must be notified an ence.

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

State Registrar

DHMH 16 Rev 6/95

30. Nema end eddress of person who completed cause of daeth (Item 23e) (Type, Print)

MD

32. Registrar's Signatura

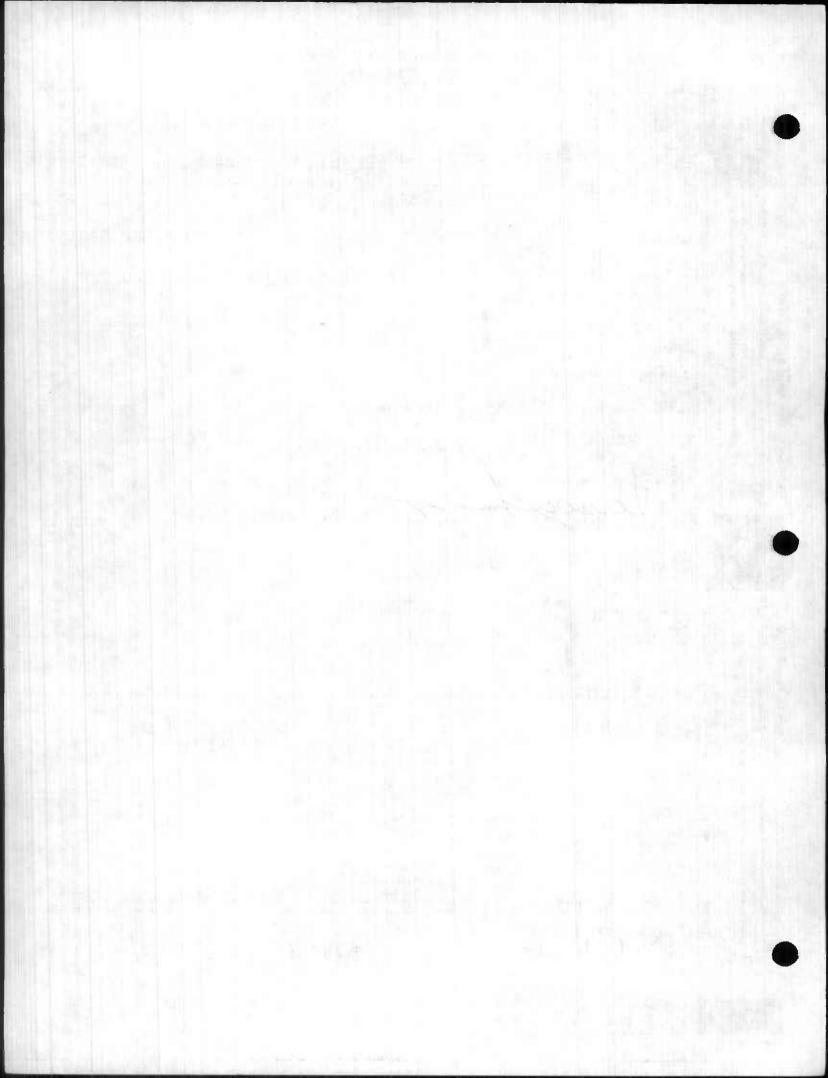
STEVEN GRUFFERMAN, 31. Dete filed (Month, Day, Year) SEP 2 7 2000

D 24348

1500 FORREST GLEN RD, SILVER SPRING, MARYLAND

2000

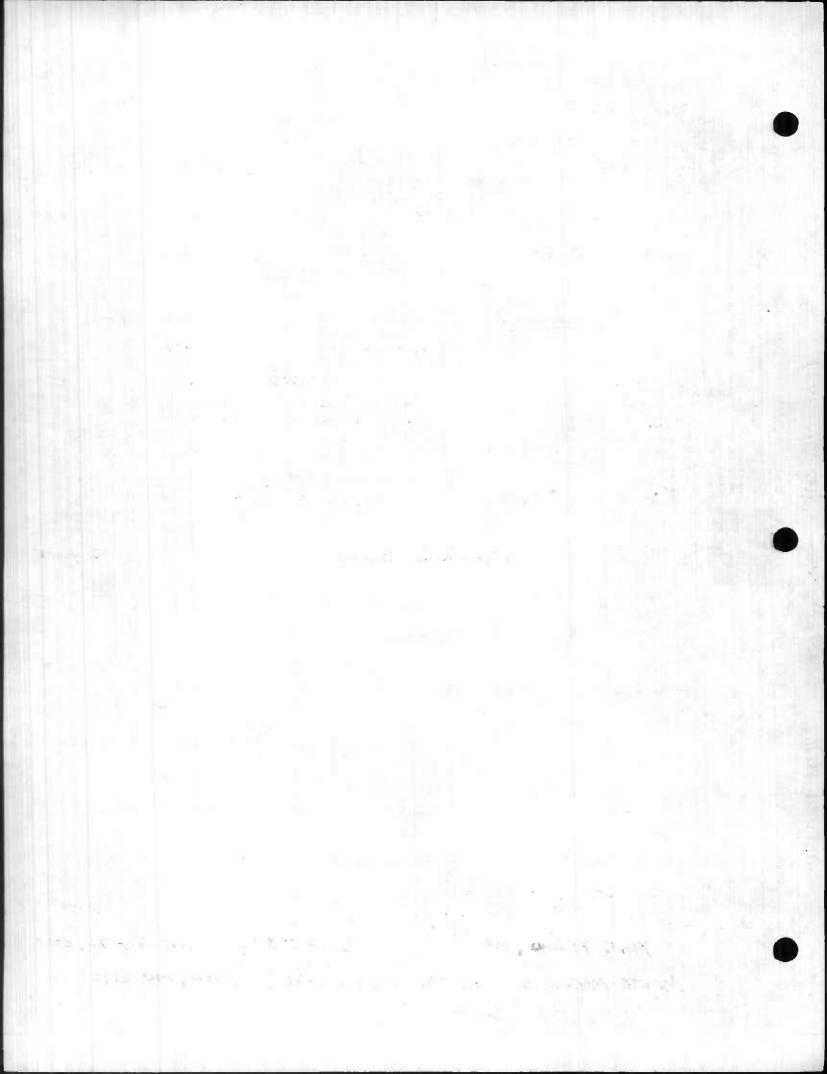
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Please Type or Print In Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certifica	te of	Death		Reg. No.	00	32032	
Physician	Decedent's Name (First, Mid	dle, Last)		Maria I		-531=	2. Dete of D Month 09	eeth Dey 22	2000	3. Time of Death	
/Medica	DAISY MILDRED					4h Cib. Tourn or I				0740	
Examine			,		-11	4b. City, Town, or l ELKTON	Location of Dea		ounty of Deeth		
Funeral	LAURELWOOD HEA 5. Social Security Number	+	ge (In yrs. last bi		er 1 Year	If Under 24 Hrs.		irth		plece (Stete or For	
Director	220-26-3931 Usual Residence of Decedent	1□M 2 X JF	81	Yrs. Months	Deys	Hours Min.	12/10/	1918	MAR	YLAND	
yland	10a. Stete 10b. Coun										
e Mer	MD TALBOT EASTON								1X Yes 2□		
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "satural", or items 23a or 28a-f ahow any injury or other treumatic event, the Medical Examinar must be notified at page.								10g. Citizen of What Count USA			
		If Yes Give	7	13. Was Dec		Hispanic Origin? (S lan, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)		Race - Amer Bleck, White pecify: WHI	, etc.	
1 21215-0020 ed within 72 hours affore than "netural", or the managed by the Modes Example of	15. Decede (Specify only high	est grade completed)	ducation 16a		Decedent's Usuaf Occupation (Give kind of work done during most of wiffe, DO NOT use retired)		king	16b. Kind	b. Kind of Business/Industry		
212 with iene. ther	Elementary/Secondary (0-12)	College (1-4or	5+) H	OMEMAKEI				OWN	WN HOME		
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Maryland d 2 should be flie th and Marylands the th and Marylands the marked other treumatic event	19e. Informent's Neme/Reletion	nship (Type, Print)	198	b. Meiling Addre	ss (Street	t end Number or Ru	ıral Route Num	ber, City or T	own, Stete, Z	ip Code)	
and	EMILY R. WAGN	ER		o. Box		ELK MILLS		_			
Baltimore, semit. Pages 1 at Department of Haa moortant: if frem; my Injury or other and		1 N Burial 2 Cremetion 3 Deemovel from State cemetery, cremetory or other piece)							GHMAN, MD		
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BOX Beth cert attendin for usa		d							i		
D. E	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.							23b. Did tobacco use contribute to the cause of de			
requires that the death centered is provided by the attendifuence the provided by the attendifuence by Physicians	1□ Yes						Yes 2E	212 No 3 Probably 4 Un			
2 2 8 W		1400					24a. Wa	is en eutopsy formed?	8	Vere autopsy find weilable prior to completion of caus of deeth?	
The law ate has be page 2 s							10	Yes 20	No 1	☐Yes 2☐ No	
r Vital I	25. Was case referred to medic examiner?					26. Place of Dee	oth (Check only	one)			
는 사람들 다	1 ☐ Yes 2 Ø No	1 □ Inpati	Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 DOA 28a. Injury et (Month, Day Year) 28b. Time of Injury 28c. Injury et Work?				Home 5 Residence 6 Other (Special 28d. Describe how injury occurred		city)		
Division of Vital ne Hospital or Attending Physicien: The 24 hours after death. The Funeral Director: After this certificat pletaty filled in by the funeral director, po	2 Accident inves 3 Suicide 6 Coult 4 Homicide	tigation d not be mined 28e. Plece of fn	28e. Plece of Injury - At home, farm, street, fectory, building, etc. (Specify)		1	1 Yes 2 No		Location (Street and Number or Rurel Route N City or Town, State)			
DIVI To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by Medical Certiff	29a. Certifier 1 Certify (Check only 2 Medica	ing Physician: To the best if Examiner: On the basis of	of my knowledge	e, deeth occurre	d at the ti	ime, date end place	, end due to th	e cause(s) ar	nd menner as	stated.	
thin 24 the P		end manner st	teted.								
o d vit	200. Org. rotate on a tribe of borta			2		se number 44783			signed (Month	22, 200	
	Monte n	I woods 1 110			D-1	77/00		26/16	- TOY TO	20,000	
	30. Name and address of perso	n who completed cause of	death (ttem 23a)	(Type, Print)	(2	treet,	BINTO	N. N	0 21	92-1	

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State of Maryland / Department of Health and Mental Hygiene

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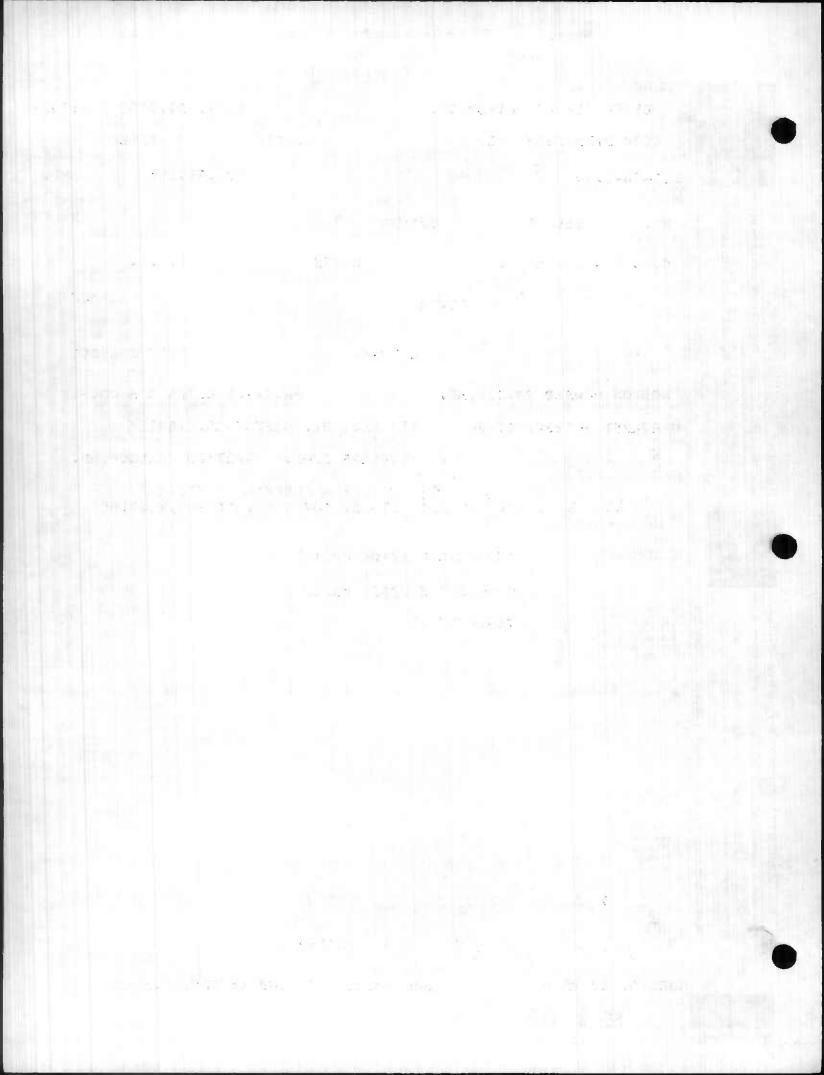
							Cer	tificate	of E	Death	F	leg. No.		2 4 0 0 0
Г			1. Decedent's Neme (Fire	rst, Middle, Last)							2. Dete of Dee	-	Yeer	3. Time of Deeth
	Physicia /Medic		HOLTON	HOWARD	POTTE	ER, JR					SEPT.	21,200		6:00pm
	Examin		4e Fecility Neme (If not	institution, give s	treet end numb	er)			41	. City, Town, or	Location of Deeth	4c. County	of Deeth	
			4070 HE	ENNESSE	E RD.					TRAPPE		TAI	LBOT	
	Funeral Director		5. Sociel Security Number 216-56-12 Usuel Residence of Dec	44	M 2□F 7.	Age (In yrs. 48	lest birthday) Yrs.	If Under 1 Months D	Year Deys	Hours Min		, Yeer)	9. Birthp Cour	elece (State or Foreign try) MD •
			10a. Stete 10b. County 10c. City, Town or Location									1	0d. inside City Limits	
	Mary	to	MD. TALBOT TH					F						1 XYes 2 □ No
	r 28a-f show	Director	10e. Street end Number	IADDO	1		rrapp:	10f. Zip Ci	ode			I Og. Citizen of V	Vhet Cour	itry?
	Herns 23e or		4070 HENNESSEE RD. 21673 U.S.A.											
	Herra 2	Funeral	11. Maritel Status		12. Wes Decede		S. 13. \	Vas Deceden	t of His	penic Orlgin? (9	Specify Yes or No-	14. Rec	e - Americ	an Indian,
21215-0020	a o	by Fu	1 Never Married 3 Widowed 4		Armed Force Fig. Yes 2 Fig. Sive Yeer or Dete	□ No		Yes, specily		Specify:	to ricen, etc.)	Specify	k, White,	ACK
0-0	CI B	Completed		Decedent's Educ			16e. Deced	lent's Usuel C	Occupa	tion uring most of wo	deina	16b. Kind of Bu	siness/in	dustry
21	within 7 ana. than "n	npie	Elementery/Secondery	-	College (1-4	or 5+)	life. L	OO NOT use	retired)	aring most or wo	ining			
	Hygian Hygian ther th	S	12				LAB	DRER					SERV	ICE
pu	S E D >	Be	17. Fether's Neme (First,	, Middle, Last)						18. Mother's Na	me (First, Middle,	Maiden Sumem	(0)	
7/8	Me Me	2	HOLTON H			R, SR.					RET EL			
Maryland	CI O M M		19e. Informent's Name/i								ural Route Numbe		Stete, Zip	Code)
	1 and Health em 27 ther tr		MARGARET 20e. Method of Disposition		MOTHE		119 leca of Dispo			· EAST	ON, MD.	21601 20c. Location -	City or To	own State
Baltimore,	20 P		1 Suriel 2 □ Cre	emetion 3 DR	emoval from Sta	ateC	emetery, crer	netory or other	er plece					
tim	permit. Pag Department Important: I any Injury o		4 Donetion 5 D		OF	MD	-	ERANS			9/27/00	HUKL	JCK,	MD.
Bal	Departm Departm Importar any Injui		21. Signature of Funeral	Service License	0	n		Name end			L SERVI	CES		
			and	d 1	all	rill							2160	1
П			23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 319 E. DOVER ST. EASTON, MD 21601 Approximate Interval Between Onset and Deeth											
	Physician /Medical		Immediate Cours /Final										1	Onset end Deem
8	Examiner		Immediate Ceuse (Finel disease or condition resulting in deeth) ISCHEMIC CARDIOMYOPATHY											
		5	Due to (or es e consequenca of):											
	be executed sician end buriel-transit	Examine		_ b	CONG		VE HE		AII	URE			i	
,	axecu n end iel-tra	Exa	Sequentially list condition if eny, leading to immed cause. Enter Underlying Ceuse (Disease or injury)	ins,	DIAL		r es e conseq T T	uenca or):						
68760,	e be rslcia	edicai	that initiated events		DIAL	DIABETES II Due to (or es e consequenca of):								
	certificate be executed uding physician end use es the buriel-transi	8	resulting In deeth) Lest	100		200 10 10	1 63 6 6011364	derica ory.						
Вох	leeth certificate b ettending physic of or use es the b	M		d										
	the deeth y the etter ached for u	Physician/	Pert II. Other significant	conditions con	tributing to deat	h but not res	ulting In the u	nderlying cau	se give	n in Pert i.	23b. Did 1	obacco use co	ntribute t	o the cause of death?
P.0	thet the dead by the detached	hy									10	res 25 No	3 Pro	bably 4 Unknown
Ś	gane de d	by												
ord	v requiras been sign should be											en eutopsy med?	ev	ere eutopsy findings eileble prior to
ecc	aw 2 S	Completed											of	mpletion of cause deeth?
<u> </u>	0 - 0	Con									101	es 2 No	1 [☐Yes 2☐ No
Ita		Be (25. Was case referred to examiner?	medical						26. Plece of De	eth (Check only o	ne)		
7	5 00	P	1 ☐ Yes 2 No	Н	ospital: 1 Inp		ER/Outpetier		Othe	4 LI Nursing	g Home 5 TResidence 6 ☐ Other (Specify)			
L C		on:	27. Manner of Deeth 1 Naturel 5	Pending	28e. Date of I (Month,	Injury Dey Year)	28b. Time of Injury		. Injury Work		28d. Describe I	ow Injury occur	red	
sio	eat the	cati	2 Accident 3 Suicide 6	investigation Could not be	2-01-00-			М		′es 2 No	004 1			
Division of Vital Record	or Attendate death Director: /	Certification:	4 Homicide	determined						City or Tov	m, Stete)	er or Hur	el Route Number,	
	pital ours a oral [29a. Certifier 1₩	Codifidae Dhua	Islam, To the he		uladaa daab	non-unad at	the stime	o data and aloc	a and due to the	and and ma		totod
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edicai				s of examine		estigation, in	my op	inion, deeth occ	a, end due to the urred et the time,	date end place,	end due t	o the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of	of cartifier	11	1	3-	10		number		29d. Date signe		/
			· Vu	1	12	0	m	DC	105	5225		9/:	27/	60
			30. Neme end eddress o	f person who co	mpleted cause of	of deeth (Item	23e) (Type,	Print)		1/1/1/e				
			NOEL L. HU	JNTE MI			606 I	UTCHM	IAN	S LANE	EASTON	, MD. 21	601	

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State

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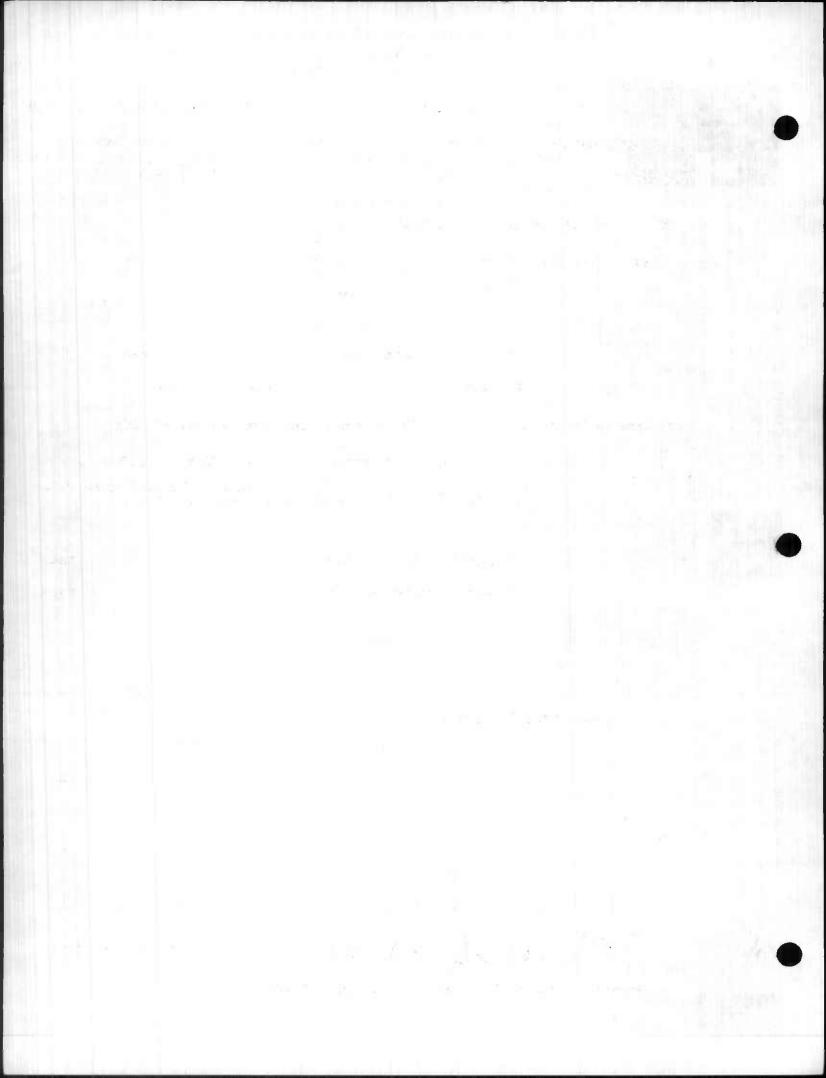


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey Yeer September 29 2000 **Physician** Paolozzi 8:10 PM Catherine /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Mariner Health Care of Laurel Prince George's Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, 5. Social Security Number 8. Date of Birth (Month, Day, Year)

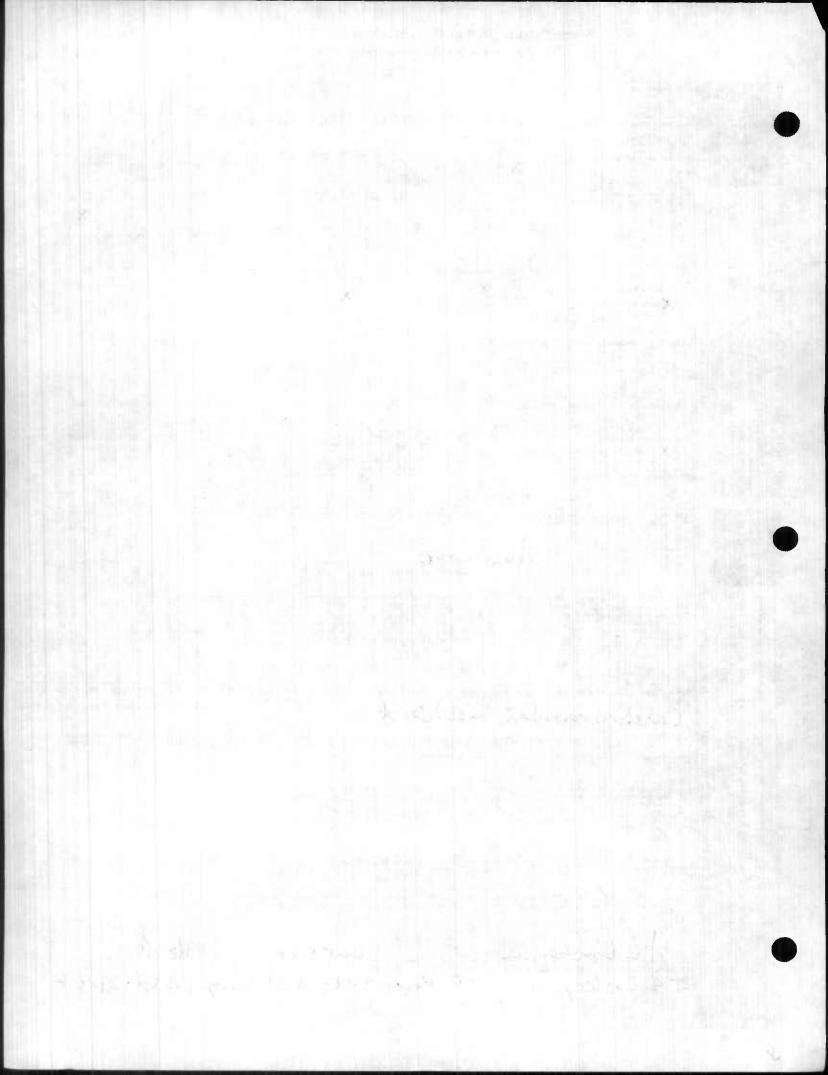
April 19, 1915 New York 7. Age (In yrs. last birthday) **Funeral** 1□м ЖХ Deys Yrs. Director 057-28-3852 85 Usuel Residence of Decedent tha Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at XXYes 2 □ No Director Prince George's Laurel 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5 items 23a death Funeral 14200 Laurel Park Drive 20707 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ②XNo If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. should be filed within 72 hours after nd Mentel Hygiene. marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: P Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if Item 27 is marked othe any injury or other traumatic event potes. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Vincent Florenze Carmela Lazzaro 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Vincent Paolozzi/ Son 120 Patrician Lane, Brownville, NY 13619 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel trom State 4 □ Donetion 5 □ Other (Specify) Calvary Cemetery 10/3/00 New Hartford, NY 21. Signature of Funeral Servica Licensee 22. Name end Address of Fecility Donaldson Funeral Home, P.A. MO1103 anuco 313 Talbott Avenue, Laurel, MD 20708 23a. Part1. Em er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or hear tailure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediete Ceuse (Final disease or condition resulting in death) Congestive Heart Failure l week Examiner Due to (or es e consequenca of): Examiner Coronary Artery Disease 2 years The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest pue Due to (or es e consequence ot): Box 68760, attanding physician for use as the buria Physician/Medical Due to (or es a consequenca of): P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 □ Probably XXUnknown signed b Chronic Renal Failure Records, þ 24b. Were eutopsy tindings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy page 2 s 1 ☐ Yes XX No 1 ☐ Yes 2 No certificata Division of Vital Jo the Hospital or Attending Physician: "
within 24 hours efter death.
To the Funeral Director: After this certifica completely filled in by the funeral director; p Be 25. Was case reterred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 410 Nursing Home 5 - Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 1 ANaturel 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurat Route Number, City or Town, Stete) 4 Homicide 29a. Certifier XX Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30-2000 D54488 enne 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 8317 Cherry Lane, Laurel, MD 20707 Bennett So, MD 31. Date tiled (Month, Day, Year) 32. Registrer's Signeture State _2 2000 Spark Registrar

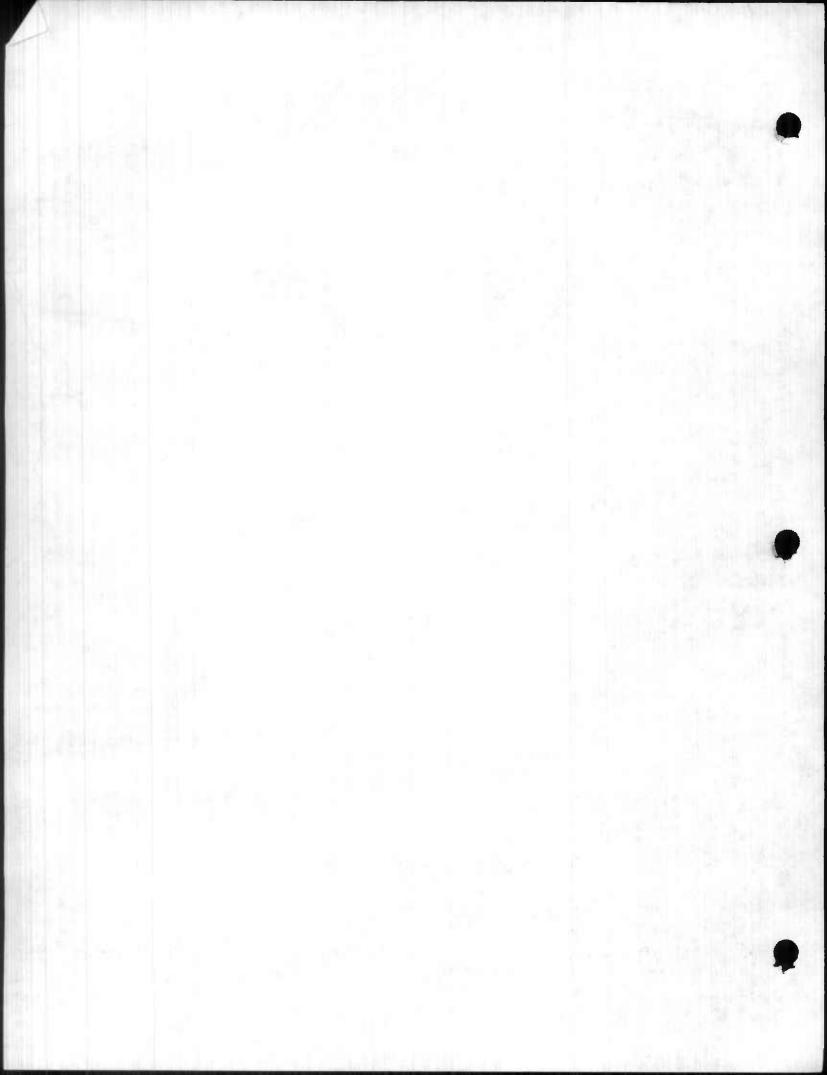


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. No	32035						
D	Decedent's Neme (First, Middle, Last)	2. Dete of Death Month Da	3. Time of Death						
Physician /Medical		September	19 2000 0530						
Examiner	4h City To	wn, or Location of Death 4c	. County of Deeth						
		ISBURY	WICOMICO						
Funeral	5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Undar 1 Year If Undar 1 Year Months Deys Hours	Min. 8. Dete of Birth (Month, Dey, Year) NOV . 15 1	9. Birthplace (State or Foreign Country)						
Director	Usuel Residence of Decedent	Nov. 15 15	933 Maryland						
and and	10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits						
Many	Maryland Wicomico Salisbury		1 Yes 2□No						
with the Marylan a or 2844 show De rodding at	10e. Street and Number 10f. Zip Code	10g. Ci	itizen of Whet Country?						
th with	139 Second Street 21801	U	.S.A						
maryland 21215-0020 south and Mental Hygiene. n27 is marked other than "natural", or ferra 23s or 28=4 show ner traumatic event, the Mental Exercise runt to notified at To Re Commissed by Eumeral Director	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Orlift Yes, specify Cuben, Mexican	gin? (Specify Yes or No-	14. Reca - American Indien,						
or its		n, Puarto Hican, etc.)	Black, White, etc.						
21215-0020 d within 72 hours affigiene.	3 Widowed 4 □ Divorced Year or Detes:		Specify: Black						
yland 21215-002 uld be tiled within 72 hours Mental Hygiene. Inted other than "natural", afte event, the Hestel Eu	15. Decedent's Education 16e. Decedent's Usuel Occupation (Specify only highest grade complated) (Give kind of work done during most	t of working	Kind of Business/Industry						
within then then	Elementery/Secondery (0-12) College (1-4or 5+)								
Sold was	12 Domestic		one						
d out H	17. Father's Name (First, Middle, Last)	er's Neme (First, Middle, Maider	n Sumeme)						
aryland should be tiled should be tiled in merked other umatic event.		elyn Polk							
Maryland d2 should be tile th and Mental Hy T is marked othe traumatic event	19e. Informant's Neme/Relationship (Type, Print) Debra Purnell (Daughter) 139 Second Street								
(1) _ = = = =	Debra Purnell (Daughter) 139 Second Stree		ocation - City or Town, Steta						
Baltimore, permit. Pages 1 er Department of Hea Important: If Nem 3 eny injury or other pages.	1 Burial 2 Cramation 3 Removel from State	9/1//							
Itim transcriptory	4 Donetion 5 Other (Specify) St Mary's Cemetery		ncess Anne, Md.						
Balt Permit. Departr Importu	21. Signeture of Funeral Servica Licansee 22. Name end Address of Fecilit Stewart Fune	ral Home							
		Salisbury, Md							
	231. Part1. Enter the disease, or complications that caused the dualin. Do not enter the mode of dying, such as shock, or heart feilure. List only one cause on each line.	cardiec of raspiretory errest,	Approximete Interval Batween Onset and Death						
Physician // // // // // // // // // // // // //	Immediate Cause (Final								
Examiner	disaesa or condition e. Pul u manc		1						
1	Due to (or es e consequence of):								
68760, icate be axecuted physician end s the burist-transit	b								
axect n end n end in l-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.								
68760, ifficate be assocuted g physician end es the burial-transit	The initiated events								
E 000 =									
Box seth cert attendin for use	d								
. 5 . 5	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	. 23b. Did tobacc	o use contribute to the causa of death'						
P.O. the the ed by the detache	Corrbnovaulen accident	1 Yes	2 No 3 Probably 4 Unknow						
es their	Corporation accident								
al Records, The law requires to cate has been signe, page 2 should be to completed by		24a. Wes en auto performed?	available prior to						
Record Her Pas be has be pe 2 sh			completion of ceuse of deeth?						
The transfer page		1□ Yes 2	2 Ø No 1 ☐ Yes 2 ☐ No						
<i>a a a b b c c c c c c c c c c</i>	25. Was cese referred to medical axaminar?	e of Death (Check only one)							
ion of Vita nding Physician: sth.: After this certific tuneral director,	1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 No	ursing Homa 5 Residence	6 □Other (Specify)						
north mera		28d. Describe how inju	ury occurred						
Vision Attending r deeth. ector: Attei by the tune	2 Accident Investigation 3 Suicide 6 Could not be								
DIVISION DIVISION Hospital or Attending 24 hours after deeth. Funeral Director: Alie tely filled in by the tune	3 ☐ Suicide 4 ☐ Homicide 5 ☐ Could not be determined 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify)	28f. Location (Street a City or Town, Ste	and Number or Rural Route Number, te)						
Div Hospital or 24 hours afte Funerel Dir stely filled in									
DIVISION C To the Hospital or Attending P Within 24 hours after deeth. To the Funerel Director. After t completely filled in by the tuners Medical Certification:	29a. Certifier 1. Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, dete en (Check only one) 1. Certifying Phyalcian: To the bests of exemination and/or investigation, in my opinion, dee end menner steted.								
To the Ho within 24 I To the Fu completel	29b. Signature and title of certifier. 29c. License number	29d. D	ete signed (Month, Day, Year)						
- F F 8		,	0/00						
1 stc	20 Norman and address of account to finished account of death (from 22a) (Type Bright)	4 7(2	000						
4	30. Name and eddress of person who doubleted cause of deeth (Item 23e) (Type, Print) THE COCKEY, MD 100 POWEN St., Sa	Vichiana 1	nd.21804						
State	31. Deta filed (Month, Day, Year) SEP 22 2000 32. Apoistrare Signeture G. Apouls	11) 6000	0 (00)						
Registrar	SEP 22 2000 / Aparks								

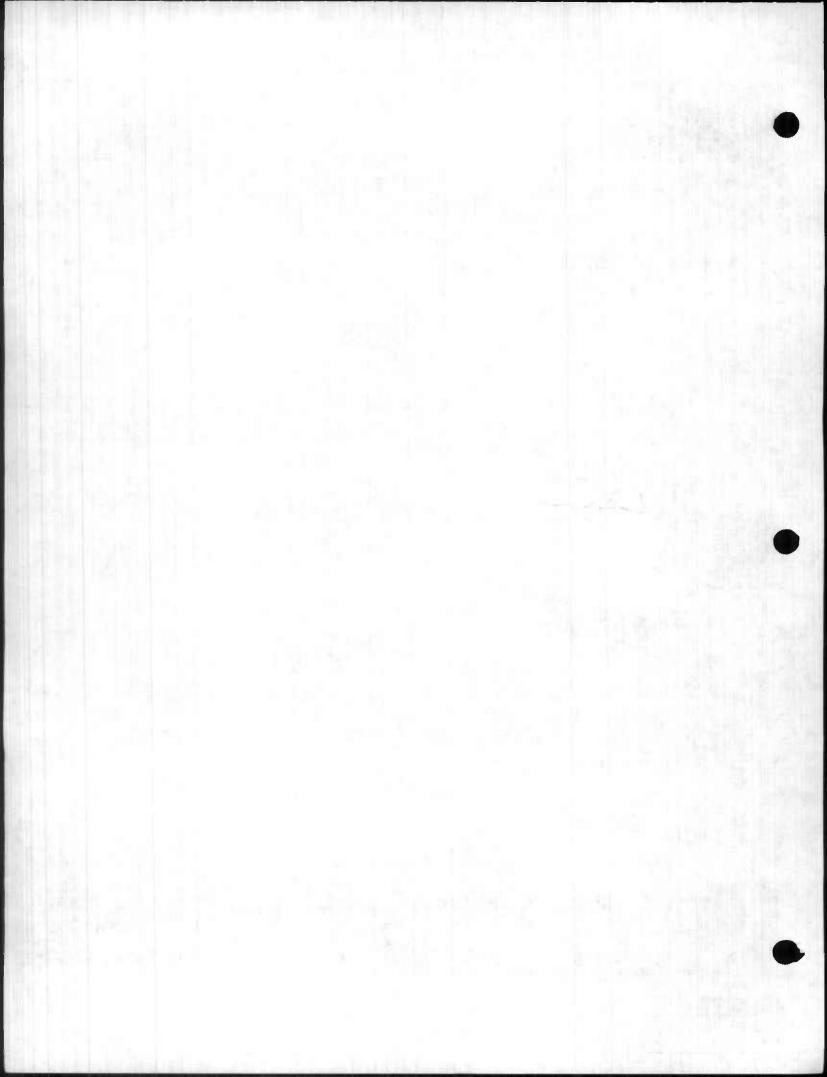


nysician	Decedent's Neme (First, Middle, Last)	ate of Death	2. Dete of De		3. Time of Death	
Medical	Mary Jane Ross	Ab City Town or	September 19, Year 524pm			
kaminer	4e Facility Neme (If not institution, give street and number) Laurel Regional Hospital	Laurel	Cocation of Death		e George's	
neral ector	5. Social Security Number 480-16-9225 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 82 Yrs. Mont	der 1 Yeer If Under 24 Hrs hs Days Hours Mir		th Year) 7). Birthplaca (State or Forei Country) OWA	
3	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location				10d. Inside City Limit	
hydens. other than "natural; or items 23s or 28s-f show ent, the Hedical Examiner must be notified at e. Completed by Funeral Director	MD Montgomery Silver Spri	ng			1□ Yes 2□N	
		Zip Code 0904		10g. Citizen of Wh.		
	1 Never Married 2 Married 1 Vec 2 This	cedent of Hispanic Origin? (pecify Cuban, Mexican, Pues 2 No Specify:	Specify Yes or No rto Rican, etc.)	14. Race - Bleck,	American Indien, White, etc.	
		Isual Occupation work done during most of wo T use retired)	orking	16b. Kind of Busin		
	17. Fether's Neme (First, Middle, Last)		ıme (First, Middle	, Maiden Sumame)		
o Be	Fred A. Criley		Pearl Al			
-		ress (Street and Number or Facefield, Sil			ate, Zip Code) 0904	
SUGE.	20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. Pleca of Disposition (cemetery, crematory) Chesapeake	or other placa)	sep 23 2000	20c. Location - Ci Beltsvi		
DUCE	21. Signature of Funeral Service Learnee 22. Name Rap 9 3 3	Service	s MD			
an examiner	Immediate Cause (Final disease or condition resulting in deeth) Massive pulmonary embol: Acute Cardiac Arrest Due to (or es e consequenca Coronary Artery Dise	of):	ary arcerre		Seconds	
ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence or consequence)					
and	d.	d				
Physician/Me	Part II. Other eignificant conditions contributing to death but not resulting in the underlying non. smoker	ng cause given in Pert I.			ribute to the cause of dea	
Completed by	HOIL SHOKEL			s an autopsy ormed?	24b. Were autopsy finding aveilable prior to completion of cause of deeth?	
E O			10	Yes 2 No	1 ☐ Yes 2 ☐ No	
Be	25. Was case referred to medical exeminer?		eeth (Check only	one)		
tion: To	27. Menner of Deeth 1 □Neturet 5 □ Pending (Month, Day Year) 28b. Time of Injury	OOA Other: 4 Nursing 28c. tnjury at Work? 1 Yes 2 No	-	idenca 6 Other how injury occurred		
completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pleca of injury - At home, ferm, street, fact building, efc. (Specify)		(Street and Number own, State)	or Rural Route Number,		
edicai C	29a. Certifler (Check only one) 1 **Certifying Physician: To the best of my knowledge, deeth occur on the basis of examination end/or investigation and menner steted.					
Σ	29b. Signeture and title of certifier	29c. License number			(Month, Day, Year)	
	I Ashan my	D53411		Septen	wher 20 15 2	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. C. Shesadri M.D. 3060 Mitchellville	Rd. #103, Bo	wie, MD	20716		



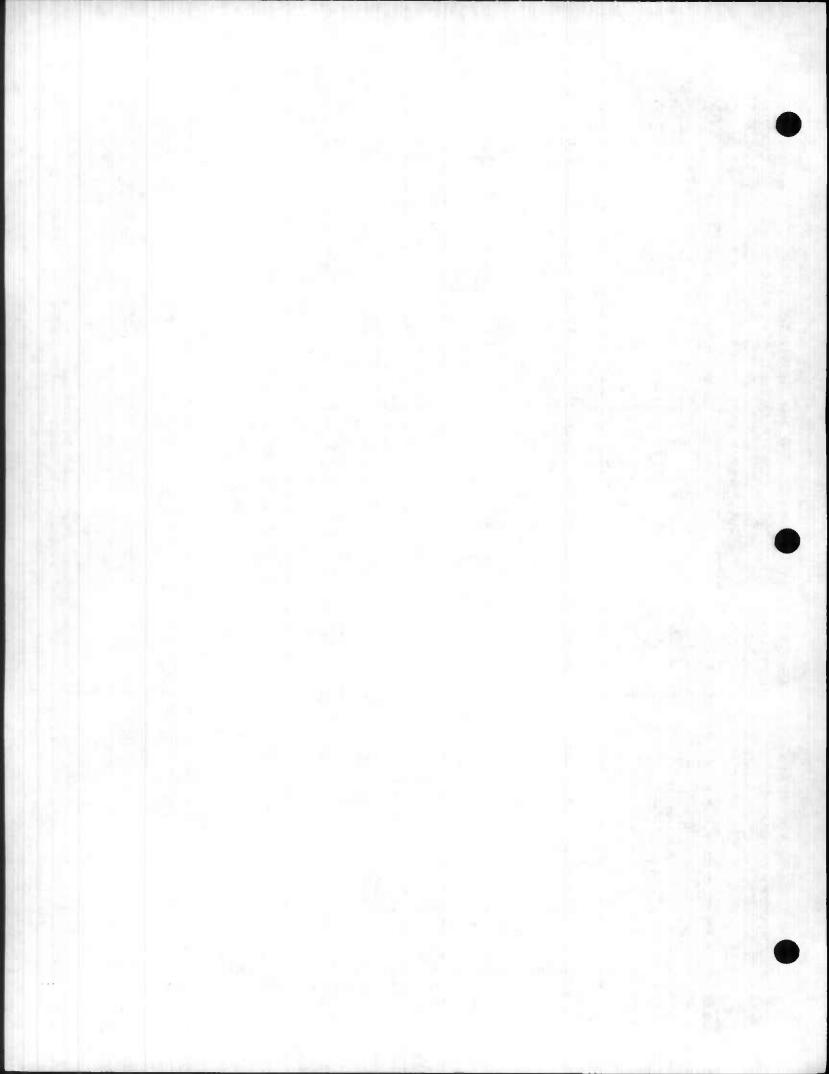
State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	Reg. No.	J 32037
Division.	1. Decedent's Name (First, Middle, La	st)		2. Date Mont	of Death h Day	3. Time of Death
Physician /Medical	ROSS ROSENBERG				EMBER 24,20	
Examiner	4a Facility Name (If not institution, given CASEY HOUSE	re street and number)		4b. City, Town, or Location of ROCKVILLE		of Death GOMERY
Funeral Director	5. Social Security Number 6. S 217-24-7543	Sex 7. Age (In yrs. last 71	birthdey) If Under 1 Year Months Days	Hours Min (Mon	of Birth th, Day, Yeer) IBER 20,192	Birthplace (State or Foreign Country) MARYLAND
Maryland a-f show	10a. State 10b. County		own or Location			10d. Instde City Limits 1 1 Yes 2 □ No
offer death with the Mainter death with the Mainter and be notified in the real Director	10e. Street and Number 11430 Strand Driv	e #413	10f. Zip Code 20	852	10g. Citizen of W	hat Country?
one s	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1\(\) Yes 2 □ No WWI] If Yes, Give Year or Dates:	13. Wes Decedent of If Yes, specify Cut	Hispanic Origin? (Specify Yes Jan, Mexican, Puerto Rican, et Specify:	or No- C.) 14. Rece Black Specify:	- American Indien, k, White, etc. WHITE
	15. Decedent's Elementary/Secondary (0-12)		6a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire BUSINESS OW	during most of working	16b. Kind of Bus AUTOMOT	siness/industry IVE REPAIR
be file to the dother word	17. Father's Neme (First, Middle, Last,)		18. Mother's Neme (First, NoRMA SAC		»)
e, Maryla 1 end 2 should Health and Men em 27 is marke ther treumatic	19e. Informant's Name/Relationship (WANEETA L. ROSENBE			n end Number or Rural Route / Drive #413 N.		
Baltimore, semit. Peges 1 e Separiment of He mportant: If item nry injury or other nre.	20a. Method of Disposition M Buriat 2 Cremetion 3 4 Donation 5 Other (Specif	Removal from State JUDEA	e of Disposition (Name of Plany, MEMORY ALL C	ARDENS SEPTEN 26,2000	BER	city or Town, Stata
Baltimo permit. Peg Department Important: In any Injury o	21. Signature of Funeral Service Licer	nsee	DANZANSKY 1170 ROCKV	ess of Facility GOLDBERG MEMOF ILLE PIKE ROCK	RIAL CHAPEL	S INC. . 20852
Physician /Medical	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the deeth. It one cause on each line. METASTATIC (ing, such es cardiac or respira	tory arrest,	Approximete Interval Between Onset and Death
Examiner	resulting in death)	Due to (or es	s e consequence of): LUNG CANCER			6yrs
Box 68760, tath certificate be executed tranding physician and for use as the bunal-transit		с.	e consequence of):			
that the death ce ed by the attendideteched for use	Part II. Other significant conditions of	contributing to deeth but not resulting	g in the underlying cause g	iven in Part I. 23b	o. Did tobacco use con	tribute to the cause of death?
E X 73		ISM			1 X Yes 2 □ No	3 Probably 4 Unknown
Cord require				240.	. Wes en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
- F # 8 0					1□ Yes 2⊠No	1 Yes 2 No
Of VItal I Physician: The this cartificate ral director, page 1: To Be Co	25. Was case referred to medical examiner?	Hospitel:	- 0	26. Place of Death (Check		
hys his ald	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Dey Year) 28	b. Time of 28c. Injury	4 Nursing Home 5 L	Residence 6 MOthe	
Division of standing P after death. The division of the funer fied in by the funer Certification:	3 Suicide 6 Could not be determined	e 28e. Ptece of Injury - At home building, etc. (Specify)	, ferm, street, factory, office		ation (Street end Number or Town, State)	er or Rurel Route Number,
To the Hospital within 24 hours. To the Funeral completaly filled	(Check only 2 Medical Exar	ysician: To the best of my knowled niner: On the basis of exemination and manner stated.	dge, death occurred at the t end/or investigation, in my	ime, date and place, and due to opinion, death occurred at the	to the ceuse(s) end men time, dete end plece, a	nner as stated. nd due to the ceuse(s)
To Town	· E.P.	Libre +	10 DC	9470		(Month, Day, Yeer) 3ER 24, 2007
	30. Name and address of person who EUGENE P. LIBRE			KENSINGTON, M	D. 20895	
State Registrar	31. Dete fited (Month, Day, Yeer) SEP 2 8	32. Registrar's Signature	B. Spons	ls		

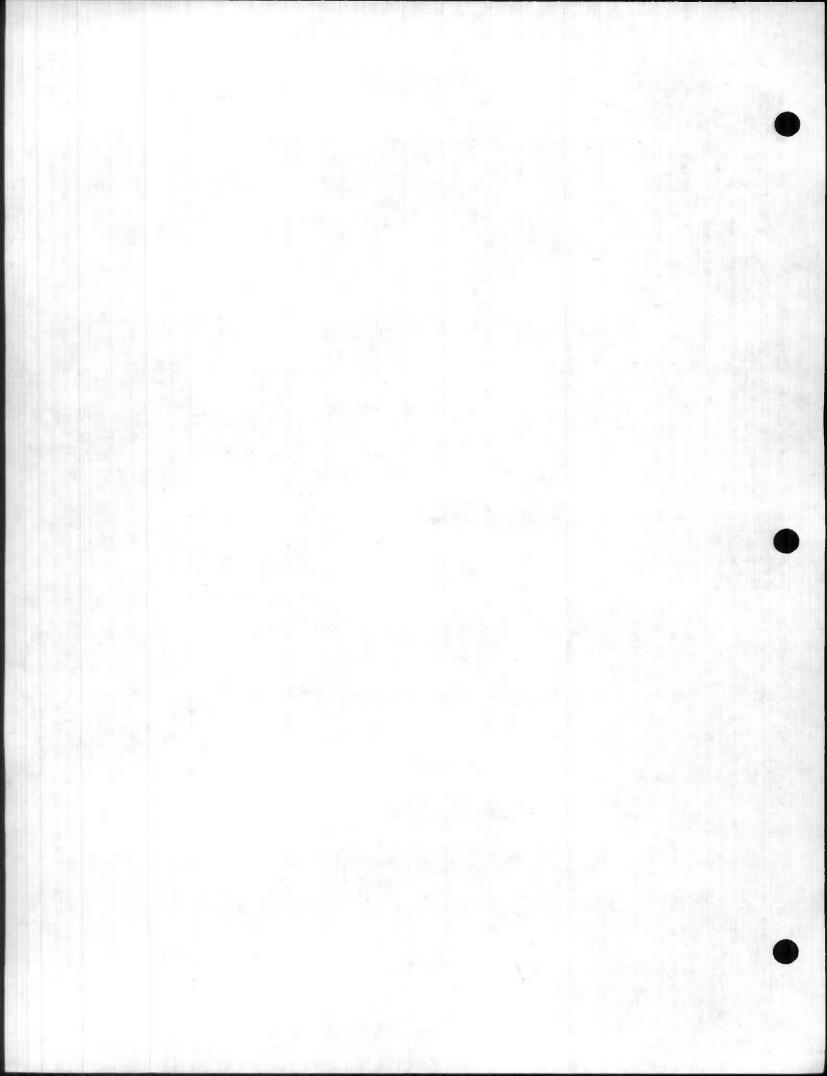


State of Maryland / Department of Health and Mental Hygiene 32038

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/Me	dical						4h City Tayan ar		ber 26,	1 - 1	2:30 AM
Exan	niner	4a Facility Neme (If not institution, give 4516 Dresden Str				1	4b. City, Town, or Kensing		4c. County	of Death	rv
Funds	al I	Social Security Number 6. S	ex 7. Ag	e (In yrs. last bir		If Under 1 Year	If Under 24 Hrs				plece (State or Foreign
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2 .		Usuel Residence of Decedent		10c. City, Tow	!!	de e					Od Inside City timbe
with the Maryland is or 25s-f show the notified at	tor	10a. Stete 10b. County Maryland Montgome	rv	Kensi							0d. Inside City Limits 1 ☐ Yes 2 X No
284	Director	10e. Street and Number				10f. Zip Code	11075 July 1		10g. Citizen of	Whet Cour	ntry?
A WITH		4516 Dresden Stree	et			20	895		Unite	d Sta	tes
O PE	Funeral	11. Meritel Status	12. Was Decedent Armed Forces?		13. Was	s Decedent of I	Hispenic Origin? (S en, Mexican, Puer	Specify Yes or No-	14. Rac	a - Americ	
15-0020 72 hours after death with the Marylar returns, or theme 23e or 28e-f show edical Examiner must be notified at	by Fu	1 Never Merried 2 Married 3 Widowed 4 Divorced	1 ⊠ Yes 2 ☐ I If Yes, Give Yeer or Dates:	No		Yes 2 No		o mozn, oto.,	Specify		
72 hou		15. Decedent's Ed	ucation		. Deceden	t's Usual Occu	pation	4.50	16b. Kind of B		
215 Med	ple	(Specify only highest grade Elementery/Secondary (0-12)	de completed) College (1-4or 5	54)	life. DO	NOT use retire	during most of wo	rking	United	Stat	es
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/lan	ToB	August Roos	TE-BT				Rose Va	n Kokelb	erg	1	
S SEE		19a. Informant's Neme/Reletionship (7	ype, Print)	19t	. Mailing /	Address (Stree	t end Number or Re	urel Route Numbe	r, City or Town	State, Zip	Code)
C 72 04 L		Louise G. Roos/Wif	е	45	16 D	resden	Street, 1	Kensingt	on, Mar	yland	20895
Tel. 10 10 10		20a. Method of Disposition		20b. Placa o camete	f Dispositi	on (Neme of tory or other pla	ice)	Date September	20c. Location		own, State
Pages Nant of nry or o		1 N Buriei 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Specify				Cemeter	,		Johnsto Pennsyl	own, .vania	a .
al the state of th	n	21. Signature of Fuseral Service Licen	300								eral Home/
0 3915	ğ	> Af M	MC	01126			Inc., 30			ery A	venue,
		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only	plicetions thet caused	the death. Do	not enter t	the mode of dyi	Marylane ing, such es cardia	c or respiratory er	2805 rest,		Approximate
Physicia	n	shock, or heart failure. List only o	one cause on each III	ne.						1	Interval Between Onset and Death
/Medica	_	Immediate Cause (Finel	REN	01	CFI	1	CAN	(0)		1	
Examine	er	disease or condition resulting in death)	e. 12 N				CAI	200			
	ē l			Due to (or as a	conseque	nca or):				1	
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oxec n en iaf-tr	Exa	if any, leeding to immediate		Due to (or as a	conseque	rica or).					
760 e be sicia	edicai	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	Due to (or as a	000000000	non of):					
X 68760, certificate be executed iding physician end ise es the bunal-trensit	Pa	resulting in death) Last		000 10 (01 23 2	conseque	1100 01).					
	M		d								
the death by the atter	Cia	Part II. Other eignificant conditions of	ontribution to death h	ut not resulting i	in the unde	arlying cause of	ven in Part I	23h Did i	obacco usa co	entribute t	o the cause of death?
P.O.	Physician	r att ii. Other eignineant conditions of	Annibuting to death b	at not resulting t	III trio diloc	onlying cause gr	von in raiti.		res 2X No		bably 4 Unknown
thet in the ded be dete	by P								ZAJ NO	•	out,
cords, P.O. Be requires that the death been signed by the atte should be detached for	D D								en autopsy	24b. W	ere eutopsy tindings vaileble prior to
Shoe shoe	Completed							репо	med?	CC	empletion of cause deeth?
The law ate has b page 2 s	E C							10	es 2K No		□Yes 2□No
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f Vita ysician: ysician: director,	Be C	25. Wes case referred to medical examiner?	Hospital:	-5-0-0		- Ot	hor	ath (Check only o		10	* •
- 5 0 O	. To	1 ☐ Yes 2 X No 27. Menner of Death	1 ☐ Inpatie		Time of	3LI DUA	4 Nursing i	Home 5 N Resident			797
ding h. After	Pol	1 ⊠Natural 5 ☐ Pending	(Month, De		Injury	M 1E	ork?]Yes 2 ☐ No	200. 200020	,,		
VISION Attending or deeth. ector: After	Cas	3 Suicide 6 Could not be		une. At home fo	arm ctroot			28f Location /	Street end Num	her or Run	el Route Number,
DIVISION Attended after deet Director:	Certification:	4 Homicide determined	building, et	c. (Specify)	am, street	i, raciory, onica		City or Tov		DOI OI FIGH	or ributo reallibor,
Division or to the Hospital or attending Ph within 24 hours after deeth. To the Funeral Director: After this completaly filled in by the funeral		20a Carifice Vi and a second	and along To the house	od ess les de -t-	e decth	novembel - t th t	ima data and at	and due to the			stated
Hose 24 ho Fund taly	edical	29e. Certifier t\ Certifying Phyone) Condition t\ Certifying Condition t\ Certifying Phyone 2 Medical Example 1	yelclan: To the best liner: On the basis of	f examination er	e, deeth od nd/or inves	stigation, in my	opinion, deeth occ	e, end due to the urred et the time,	date end plece,	and due t	o the ceuse(s)
To the Hospital within 24 hours a To the Funeral C completely filled	Med	29b. Signeture and title of certifier	end manner ste	91 9 U.		29c. Licen	sa number		29d. Date signe	ed (Month	Day Year)
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20+	1	/Cicharo L	ser	Own_			7311		-ebremo	EI Z0	, 2000
		30. Neme and address of person who o									
		Richard H. Pollen			nect	icut Av	enue #606	, Kensi	ngton, M	lary1	and 20895
	State	31. Date filed (Month, Day, Year)	32. Registr	er's Signature	4	don 4					



			Certificate o	Deam	Re	g. No.	
Physician	Decedent's Nama (First, Middle, Last ARDEANIA	REDDIX		Hast	2. Data of Death		3. Tima of Death 7:07 AM
/Medical	An English Name // not institution of			4b. City, Town, or I		4c. County of D	
Examiner	Washington A	Adventist Hos		Takoma	Park	FNOM	TGOMERY
Funeral Director	217-32-0244	7. Aga (In yrs. las	t birthday) If Undar 1 Yas Months Day		8. Data of Birth (Month, Day, Apr. 14	Year) 9.	Birthplaca (Stata or Foraign Country) Wash. DC
pue *	Usual Residence of Decedent 10a. Stata 10b. County	10c. City, 1	Town or Location				10d. Insida City Limits
vith the Maryl t or 28a-f sho be notified at Director			Hyattsvil				X□ Yas 2□ No
		enue	10f. Zip Code	20781	10	og. Citizan of What U.S.	
020 cm cm c	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 双☐ No If Yas, Giva Yaar or Datas:	13. Was Decedant of If Yas, specify Co	f Hispanic Origin? (Suban, Maxican, Puart o Spacify:	pecify Yas or No- o Rican, atc.)		American Indian, Vhita, atc. Black
1 21215-0 ed within 72 ho sypiene. wr than 'naturn t, the Medical.	15. Decedent's Ed (Specify only highest gra		16a. Decedant's Usual Occ	upation a during most of wor	kina	16b. Kind of Busine	ass/industry
The sale	Elementary/Secondary (0-12)	College (1-4or 5+)	(Giva kind of work dor lifa. DO NOT usa reti		nu ig		
	12th		Homema			Home	9
Be week	17. Fathar's Nama (First, Middla, Last)				na (First, Middle, A		
Yield Went	Jasper Jorda	a		Mai	ry Brigh	1t	
, Maryland and 2 should be lise with and Mental Hy of 7 is marked oth or traumatic event To Be C	19a. Informant's Name/Ralationship (1) Emory E. Reddi:	,, ,	19b. Mailing Addrass (Stree 5212 57th				
Pages 1 and nart of Health ret. If New 27 rry or other 2	20a. Mathod of Disposition 1 The Burial 2 Cremation 3 The American 4 Donation 5 Other (Specify	Hemoval from Stata	oe of Disposition (Nama of natary, cramatory or other p Memorial (claca)		20c. Location - City Sandy	
Demit. Permit. Popertim. P	21. Signatura of Juneral Service Licen		22. Nama and Add		AL HOME		
	23a. Part1. Enter the disease, or compshock, or heart failure. List only	Howa		ILLE, MD	20850		Approximata
BOX 55/50, eath certificate be executed attending physicien end attending physicien end attended to the burial-trensit at a clan/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	b. Chrme Dua to (or a c. Sarcorde	is a consequence of): Sequence of): Sequence of): Sequence of):	hue le	ing di	un	
death of the attended for us							
		u.					
. 0 00		intributing to death but not resulti	ing in tha undarlying causa	givan in Part I.		becco use contrit	bute to the cause of death? □ Probably 4-□ Unknown
ew requires that the d se been signed by the 2 should be detached		ntributing to death but not rasulti	ing in tha undarlying causa	givan in Part I.		98 2□ No 3[n autopsy 2	1
he lew requires that the de hes been signed by the age 2 should be detached ompleted by Physical physi		ontributing to death but not resulti	ing in tha undarlying causa	givan in Part I.	1 □ Ye	n autopsy ned?	4b. Wara autopsy findings available prior to completion of cause
The lew requires that the date has been signed by the page 2 should be detached Completed by Physi	25. Was case referred to medical	ontributing to death but not resulti	ing in tha undarlying causa		1 □ Yo	n autopsy 2: ned?	4b. Wara autopsy findings available prior to completion of cause of death?
Nytidian records, F.C. hysician: The lew requires that the dhis certificate has been signed by the director, page 2 should be detached.	25. Was case referred to medical examiner?	Hospitel: pompatient 2□EF	P/Outpatient 3□ DOA 8b. Tima of 28c. In	26. Plece of Dec Other: 4 ☐ Nursing H	1 Yes 24a. Was a perform 1 Yes ath (Check only on lome 5 Rasida	n autopsy 2: ned?	4b. Ware autopsy findings available prior to completion of cause of death? 1 Yas 2 No
or VII. Mecords, F.C. hysician: The lew requires that the discontificate has been signed by the all director, page 2 should be detached. To Be Completed by Physi	25. Was case referred to medical examiner?	Hospitel: Mapatient 2 EF 28a. Deta of Injury (Month, Day Year) 28e. Place of Injury - At hom	R/Outpatient 3□ DOA 68b. Tima of 28c. Ir Injury M 1	26. Plece of Dec Other: 4 □ Nursing H jury at Vork? □ Yas 2 □ No	24a. Was a perform 1 Ya ath (Check only on lome 5 Rasida 28d. Dascribe ho	n autopsy 2 ned? 2 No 2 N	4b. Ware autopsy findings available prior to completion of cause of death? 1 Yas 2 No
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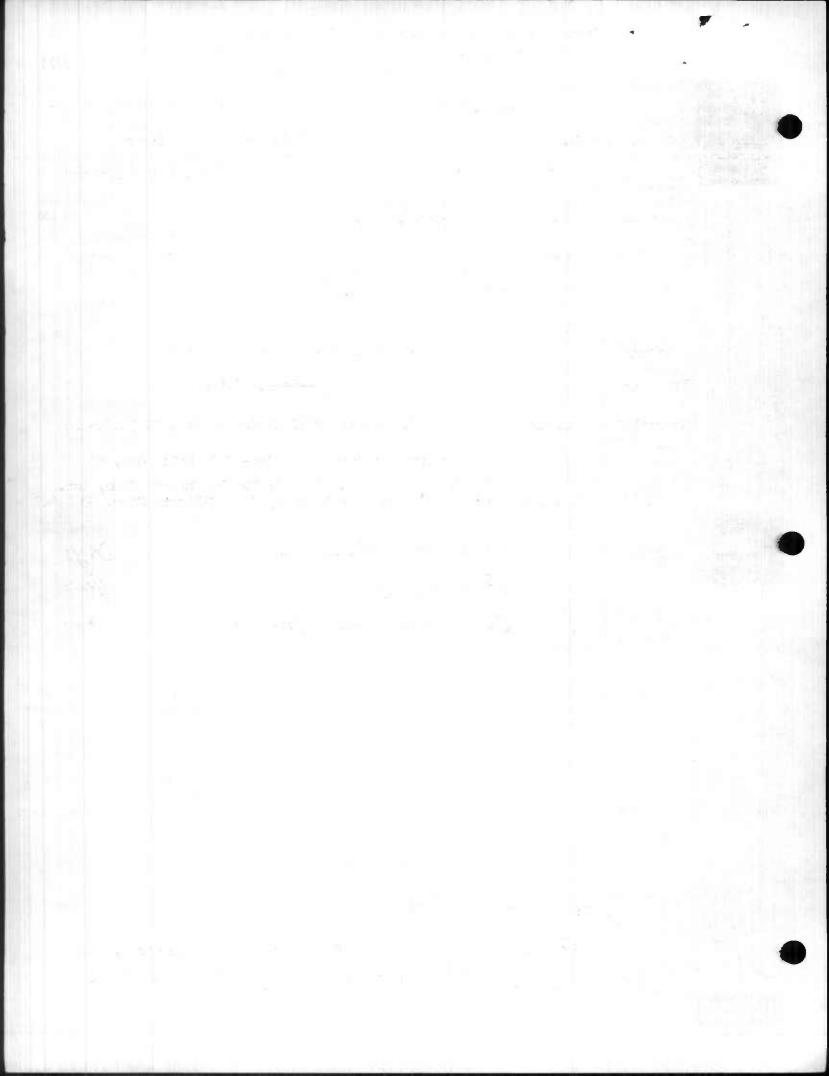


State of Maryland / Department of Health and Mental Hygiene

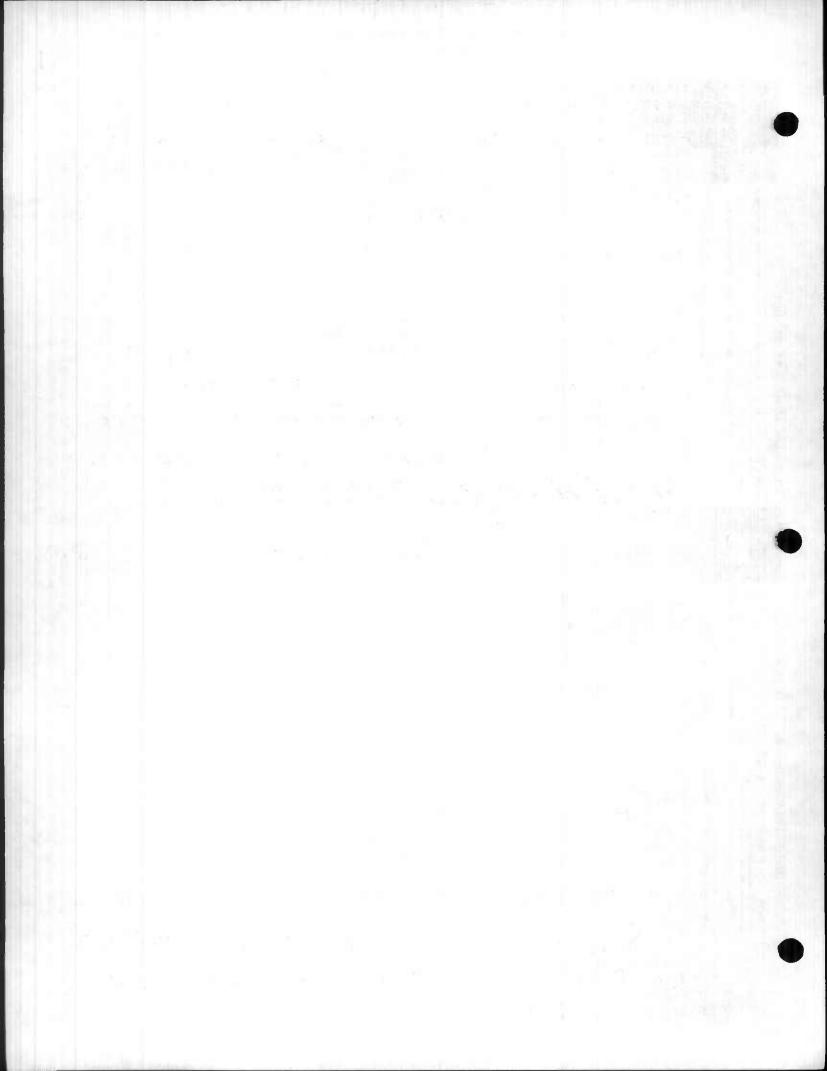
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32040

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** John G. Rapp 2000 October 11:00am /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 9966 Oak Lea Ct. Ellicott City Howard If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) **Funeral** Deys 1 M 2□ F 92 Yrs Director 215 07 2643 Sept 10, 1908 Maryland Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinal must be notified at 1 Tyes 2 No Director Maryland Howard Ellicott City 10e. Street end Numbe 10f. Zip Code 10g. Citizen of Whet Country? 2826 Pinewick Road 21042 United States Funeral 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1√ Never Married 2 Married Baltimore, Maryland 21215-0020 *natural", or 1 ☐ Yes 2 No Specify: þ Specify 3 Widowed 4 Divorced white Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 72 th and Mental Hygiene. 7 Is marked other than "ne Elementery/Secondary (0-12) College (1-4or 5+) unknown Warehousing Supervisor Retail 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Surneme) Lula E. Piston Lula E. Peaston John Rapp 19e. tnforment's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is m any Injury or other traum 2826 Pinewick Road Ellicott City, MD 21042-2204 Leonard Rapp/Brother 20b. Placa of Disposition (Neme of cemetery, cremetery or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBuriel 2 Cremetion 3 Removal from State 10-6-2000 | Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) Western Cemetery 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** ASPIRATION Precincula /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Due to (or es e consequença of) AKEN SONISM sician and burial-trensit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) physician a Heart feel and auge street Box 68760 Physician/Medical Por ed by the aid Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes TO No 3 Probably 4 Unknown signed t Records. by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy certificate has page 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Group Home 10 1 Yes 2 No After this 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homlcide 29e. Certifier 1 Contifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted. Medicai (Check only 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) 29b. Signeture end, title of ce 29c. License number 29d. Date signed (Month, Dey, Yeer) October 4, 2000 30. Name engleddress of person who completed cause of deeth (Item 23e) (Type, Print) GORC RUNE, 60 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture State Registrar



					Certifi	icate of	Death		F	Reg. No.	0 (020	41
Discorto		1. Decedent's Neme (First, Middle,	Last)					2	2. Date of Dec	eth	Male .	3. Time	of Deeth
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Director		195-42-1388	1□ M 21 F	82	Yrs.		110010		8/3/19	18 /	SOUTI	H"CARC	OLINA
pue *		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Tow	n or Location	in.					Т.	tOd Incide	Oh Al-II-
should be filed within 72 hours effer death with the Manyland nd Mental Phyllene. merked other than "natural", or items 23s or 28s-f show umsitic event, the Medical Examiner must be notified at	5	VA N/A		VIRGINI							'	10d. Inside (s 2 No
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m 23	Funeral	11. Maritei Status	12, Wes Decedent	Ever in IIS	13 Was I		Hienenic Orlo	in? /Speci	ify Yes or No-		o - Americ	cen Indien,	
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0,1	by	3 Widowed 4 □ Divorced	if Yes, Give Year or Detes:	140	1 🗆 Y	res 2⊠No	Specify:			Specif	y: WHIT	(E	
al la	be	15. Decedent's	Education	16a.	. Decedent's	s Usuel Occu	petion			16b. Kind of B	usiness/in-	dustry	
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Ment rrked rtic e	70	SAMUEL G. VEREE	N				KA	THERI	NE VER	EEN			
4 6 5		19a. Informent's Name/Reletionship	(Type, Print)	19b	. Mailing Ad	idress (Stree	t and Number	r or Rural I	Route Numbe	r, City or Town	State, Zip	Code)	
Heaith item 27 other tr		JAMES A. RUSS /	SON	2	200 TH	HE POI	NT LAN	E ST	EVENSV	ILLE, M	D 216	666	
If iter or off		20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3	□Removal from State	20b. Plece of cemeter		n (Name of ry or other pla	rce)		Dete	20c. Location	City or To	own, State	
Depertment of I Important: If ite any injury or of once.		4 Donetion 5 Other (Spe	city)	CHESA	PEAKE	CREMA'	TION C'	TR 9/	/18/00	STEVENS	SVILL	E, MD)
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	1	12/20				D.) or a	0		11101	- 0		
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Ch		31. Dete filed (Month, Day, Year)	32 Registe	ár's Signeture	/	who r	·		mi rei	VV(V)	0	161	>
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Division of Vital Records, P.O. Box 68760,

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DINESH B-SH4H, M.D.; 205; JOHNSON HTS MED

BLDG, CUMBERLAND, MD

SEPTEMBER 14th

23334

31. Data files (Magth Day Y23000 State Registrar

2. Registrar's Signature Spork

M-D

State of Maryland / Department of Health and Mental Hygiene

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					Cei	rtificate	e of I	Death			Reg. No.		La La	.040
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	Physician	JOHN MICHAEL	RYAN							Month SEPTEN	Dey IBER 1		7 on 7:	35 P. M.
	/Medical Examiner	4a Facility Name (If not institut		umber)			4	b. City, To	wn, or Lo	cation of Deal		ounty of		
	Examine	10114 CRYSTAL	TANE NU				1	FROST	BIIRC		AT.	LEGA	ANY	
-	Funeral	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bi				(Stete or Foreign
	Director	219 56 9501	1X M 2□ F	50	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Di APRIL	ey, Year)	50 M	Country)	(Stete or Foraign
Щ	Birector	Usual Residence of Decedent		1 30				1		AFKIL	10 19.	JO FI	MILLA	ND
	land W M	10a. State 10b. Coun	ty	10c. Cit	ty, Town or Lo	cation		H, H,					10d. li	nside City Limits
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	or Herns 23a aminez must b y Funeral I	10114 CRYSTAL		and and Street in 11	10		1532		:-!-0 (D		U.S		Amarican Inch	dian
	or de un	11. Marital Status	Armed F		,S. 13.	Yas Deced	ify Cuba	ispanic On an, Mexicar	n, Puarto	ecify Yes or No Rican, alc.)	14.		American In Whita, etc.	idien,
20	ar, or the by F	1 Never Merried 2 Me	If Yes, G			1□ Yes 2	No	Specify:			S	pecity:		
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2	up Case	Elementary/Secondary (0-12) College	(1-4or 5+)	life. I	DO NOT us	e retired	9)						
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yla y	Menta Menta sriced afficed To E	VICTOR W. RYA	N, SR.					MARGA	ARET	Noom!	GREEN			
Maryland	and	19a. Informent's Name/Relation	nship (Type, Print)		19b. Mailir	ng Address	(Street	and Numb	er or Rura	Aoute Numl	er, City or T	own, St	ete, Zip Cod	(e)
	atth atth	CAROLE RYAN /	WIFE		137	ORMAN	ID S'	TREET	, FR	OSTBURG	G, MD	2153	32	
5	-1 1 6	20a. Method of Disposition			Place of Dispo	sition (Nam	e of	an)		Date	20c. Loca	tion - Cit	ty or Town,	State
Baltimore,	Pages nett if lis iny or o	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other		n State				<i>(</i> 0)	01/5	00/00	FORU	A DITT	MD	
Ē	Departmen reportant: any injury ation	21. Signature of Femoral Service) EC	KHART	. Name and		es of Facili		20/00	ECKH	IKI,	МП	
Ba	Dept.	10.				WERS				P.A.				
		Chell	Dell.	4	60	W. M	AIN	ST.,	FROS	TBURG,	MD 2	1532		
	_	23a. Pert1. Enter the disease, shock, or heart failure. Li	or complications that st only one cause on	caused the deat each line.	h. Do not ent	er the mode	of dyin	g, such es	cardiac c	or respiretory	errest,		Inte	roximate rvel Between
	Physician												Ons	et and Deeth
ď	/Medical	Immediate Cause (Final disease or condition	AR	TERIOSCI	LEROTTO	HEAR	T D	TSEAS	E				YF	ARS
	Examiner	resulting in death)	a		or es a consec									
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	ficate be executed physician end is the burial-transit	Sequentially list conditions	b		or es a consec	uence of):						-		
ó	EX Part	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury			CHALL TO THE STATE OF									
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Ď	es that the death or up of the attentioned by the attention by Physician	D 44 000 1 100 1			A					1 001 011			** * * * *	
P.O.	he d the ched	Pert II. Other significant condit	tions contributing to d	death but not res	ulting in the u	nderlying ce	euse giv	en in Pert I	1.					cause of death?
	ad by deta	HYPERTENSION	J							1 🗆	Yes 2	No 3	Probably	Unknown
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ec C	as by 2 st												of death	tion of cause
ď	The Is had so th									10	Yes 250	No	1 ☐ Ye	s 2 No
a	entifica ector, p	25. Was case referred to medic	el		B) E.			26 Piace	e of Death	(Check only			- 23	
>	hysicianis certification direction	examiner? Yes 2 No	Hospitel:	Inpatient 2	FR/Outpaties	t 3 DO	A Oth	er	ursing Ho	1/	idence 6	Other	(Specify)	
ō	Phy ralls	27. Manner of Death	28a. Dete	e of Injury	28b. Time of		Bc. Injun			28d. Describe				
0	ding Afte fun	Natural 5 Pend		nth, Day Year)	Injury	м		k? Yes 2□	No		NEAD .			
Division of Vital	tal or Attending P is after death. el Director: After t led in by the funara Certification:	3 ☐ Suicide 6 ☐ Coul	d not be	e of Injury - At he	ome form str	and factory				28f. Location	Street and I	Vumber	or Bural Box	ute Number
2	or A	4 Homicide	mined 266. Plac	ding, etc. (Specif	y)	501, 100tory,	Onioo				wn, Stete)			
		On Continu												
	n 24 hound n 24 hound ne Funer pletely fill edical	(Check only Q Medica	ing Physician: To the I Examiner: On the l	basis of examina										
	the line	one)	end mer	nner steted.										
	To the Within To the Common Co	29b. Signature and title of certif				29c.	License	e number			29d. Data s	igned (Month, Dey,	Year)
	20	1/2011	hur	_			D09	157			Septem	ber	17, 2	2000
		30. Name and address of perso	who completed cau	use of death (Iten	n 23a) (Type.						1		,	
	Mis	PAUL SNOW, M.					ND.	MD 2	1502					
	State	31. Detection Magth Pay Yea		Registrar's Signa			,		1502					
	State	L [] U] 200	0											

180° 13° 0° 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth Month **Physician** September 16 2000 **EDNA** ROSS /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY 7. Age (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Dey, Year) **Funeral** Months Deys Hours 1 M 2 F 216-20-7828 Yrs. 74 Director April 16,1926 Usuel Residence of Decedent the Merylend 10a. Stete 10b. County 10c. City, Town or Location 28a-f show the Medical Exercises must be notified at Worcester Maryland Ocean City Director 10e. Street and Number 10f. Zip Code 6 12832 Whisper Trace Drive 21842 23a Funeral Hema 72 hours after

10g. Citizen of What Country? USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 14. Race - American Indian. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Black, White, etc. 1 Never Married 2 Merried 1 Yas 2 No Specify: Specify: P White 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Statistical Supervisor Federal Government 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Ronald Clarke Emma Wallberg 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Barbara E. Mills/Daughter 3898 Kingston Oak Cove, Oviedo, FL 32765 20b. Plece of Disposition (Neme of cematery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremetion 3 ☐ Removel from State 9/18/00 Salisbury Crematory Salisbury, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22, Name end Address of Fecility Holloway Funeral Home Professional Association 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest shock, or heart feitura. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximete Intervel Between Onset end Death

Physician /Medical Examiner

permit. Pagas 1 end 2 Department of Health a Important: if item 27 la any injury or other tracence.

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filed within 7 Hygiene. other than "n

end 2 should be and Mental la marked

Baltimore, Maryland 21215-0020

216-20-

P.O.

or Attending

To the Hospital within 24 hours a To the Funeral C completely filled

Examiner pue ettending physician Physician/Medical es the 9 signed by t by Completed this certificate has page Be Medical Certification: To

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of): Due to (or es e consequence of):

SERSIS

Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case refarred to medical 2K No 1 Yas

Hospital: 1 Hopatient 2 ER/Outpatient 3 DOA 28b. Time of

5 Pending investigation 6 Could not be determined

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Md.

26. Piece of Deeth (Check only one)

28d. Describe how injury occurred

1 | Yes

24a. Was en autopsy performed?

1 Tyes

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a Certifier 29b. Signature and title of

27. Manner of Death

1 Matural 2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Yeer) 29c. License number

21801

empleted cause of deeth (Item 23e) (Type, Print) 30. Neme and eddress of person who co

100051743

SCHEMIA

09/16 00

23b. Did tobacco use contribute to the cause of death?

20 No 3 Probably 4 Unknown

24b. Were eutopsy findings eveileble prior to complation of cause of deeth?

2 No

3. Time of Death

459

Birthplace (State or Foreign Country)

10d. Inside City Limits

1XXYes 2 □ No

Maryland

Day

Year

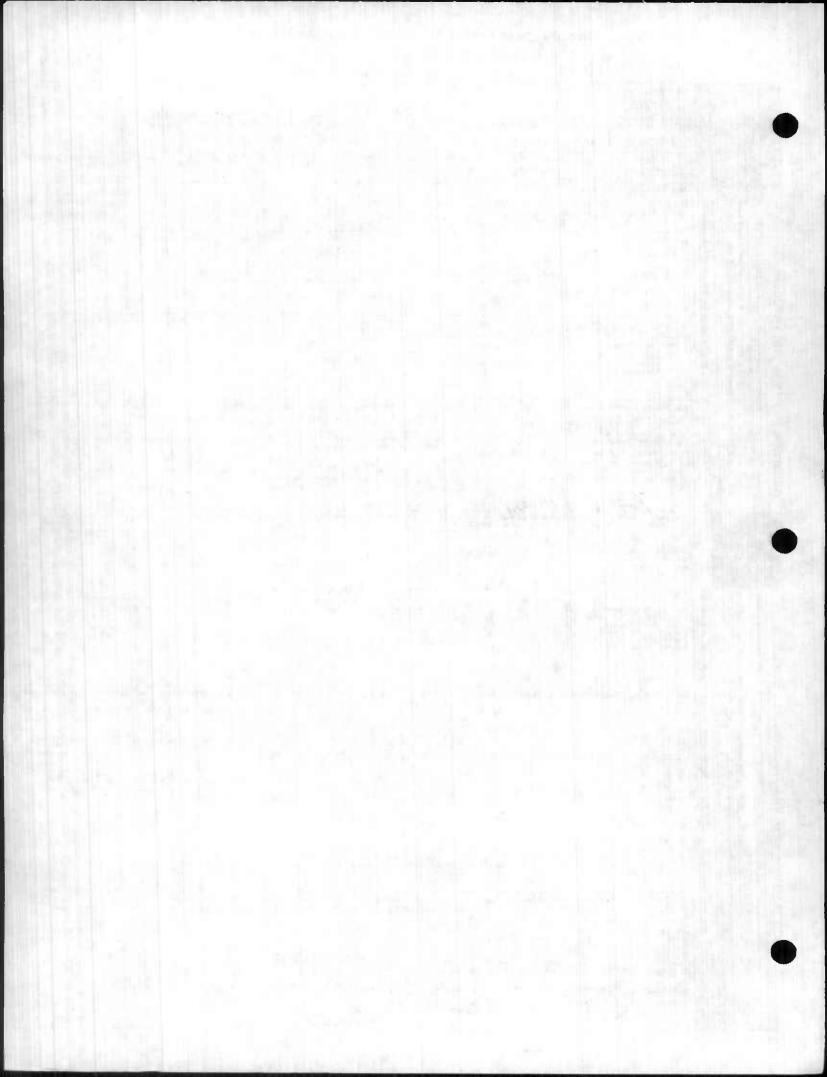
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4c. County of Death

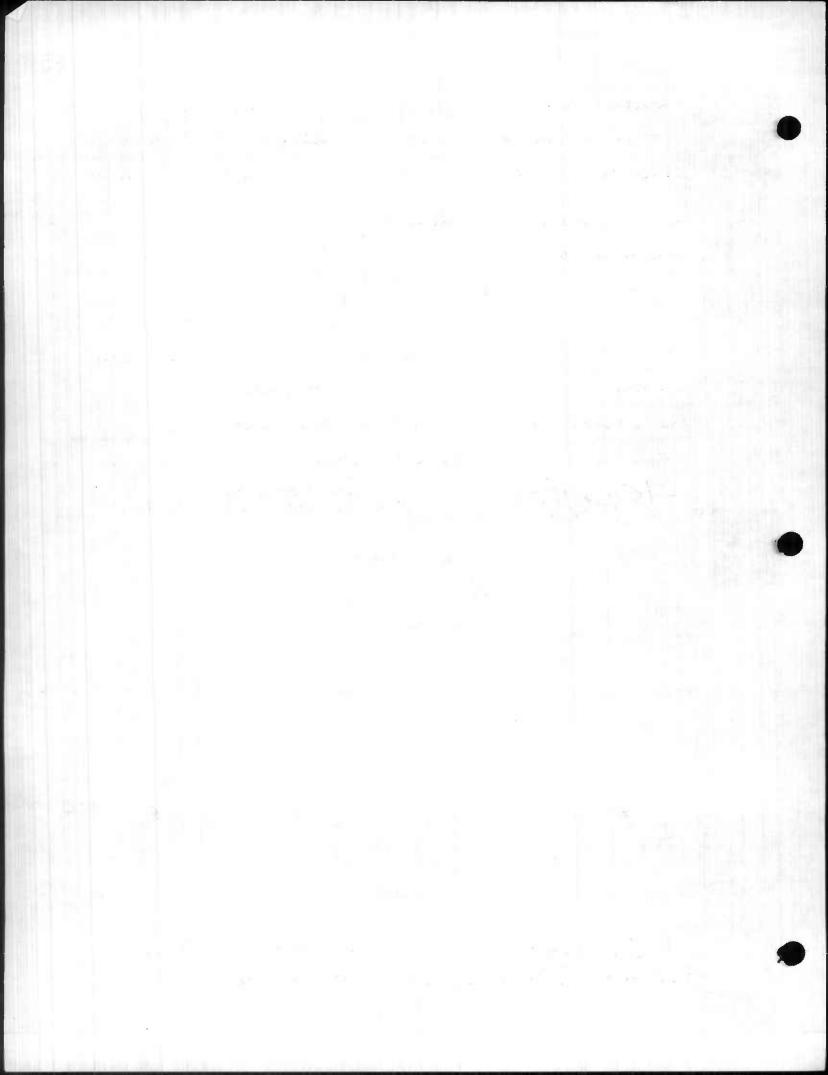
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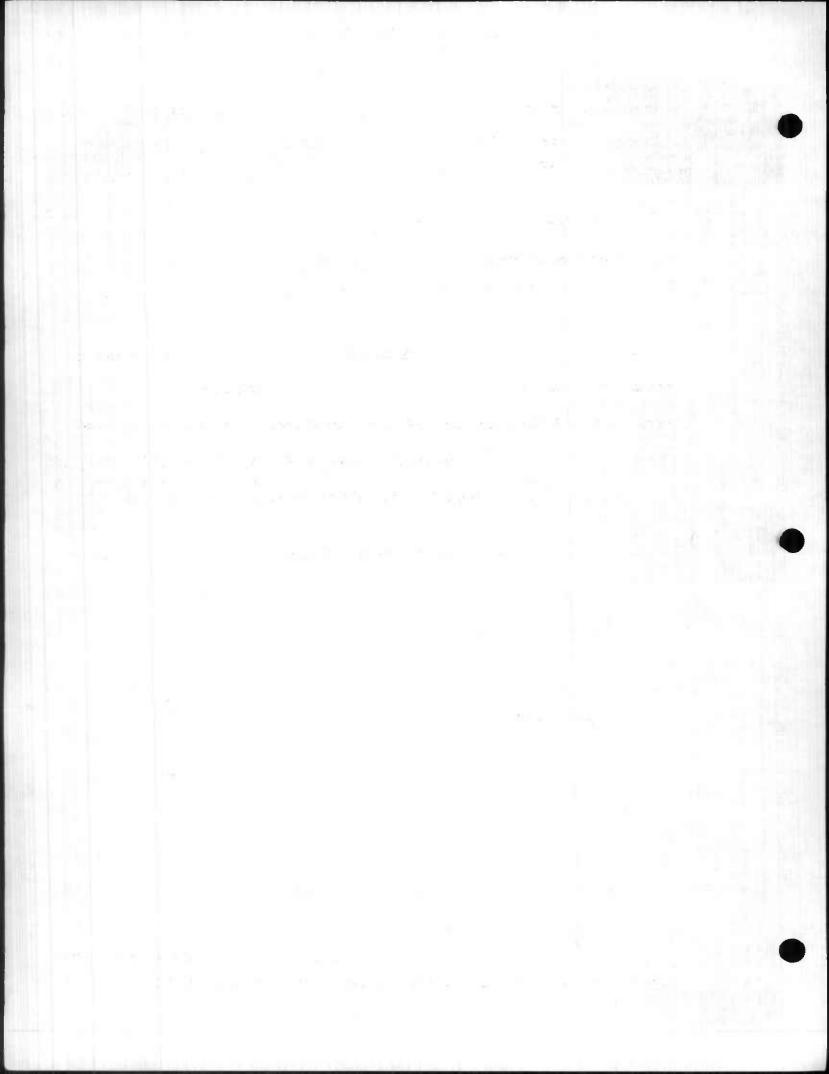
145 E. CARROLL ST 32, Registrer's Signeture



Physic	_				Cel	rtificate c	Dealli		Reg. No.	0 02	
/Medi		1. Decedent's Neme (First, Middle, Margaret G. Ro						2. Dete of De Month Septemb	Davi	Year	ime of Deeth
Exami		4a. Fecility Neme (If not institution, Peninsula regi			enter		4b. City, Town, Salisbu	, or Location of Deet			
Funeral Director	P	221-03-8996	. D D	7. Age <i>(In yrs</i> 86	(lest birthday) Yrs.	If Under 1 Ye Months De	ar If Under 24		th y, Yeer)	9. Birthplace (\$ Country) Maryland	State or Foreig
a-f show	ctor	Usuat Residence of Decedent 10e. State 10b. County MD Wicomi	.co		ity, Town or Lo	ocation					side City Limi
3a or 28	al Director	10e. Street end Number 28845 Adkins Roa	d			10f. Zip Cod	875		10g. Citizen of US		
d within 72 hours effer deeth with the Maryland jiens. r than "netural", or liems 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Dece Armed For 1 Yes If Yes, Giv Year or De	rces? 2⊠ No e		Was Decedent of If Yes, specify C		? (Specify Yes or No ruerto Rican, etc.)	- 14. Rac Bla	ca - American Ind ick, White, etc.	lien,
C 1 2	Completed	15. Decedent's (Specify only highest Elementery/Secondery (0-12) 1 2	Education grade completed) College (1	-4or 5+)			cupation ne during most of ired)	working		susiness/industry	
be file tal Hy d othe event,	To Be Co	17. Fether's Name (First, Middle, La J.C. Green	ist)		care	eteria		Name (First, Middle	, Maiden Sumer	School	
permit. Peges 1 and 2 should Department of Heeith and Man Important: If Item 27 is merke any Injury or other traumatic. once.		John L. Roberts, 20e. Method of Disposition 1 Roberts - Comment of Disposition 1 Roberts - Comment of Disposition 1 Roberts - Comment of Co	Son	St	28845 Place of Dispondentery, cremetery, cremetery, Steph	Adkins sition (Name of metory or other) ens Cem 2. Name and Ad	Road, D lolace) etery dress of Fecility	per Rural Route Numb	21875 20c. Location Delmar	- City or Town, St	
Physician /Medicai Examiner	-	Immediate Ceuse (Final disease or condition resulting in death)	еС	ande	or es e consec	west				Onse	t end Deeth
certificate be executed nding physician and use as the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In death) Last	b	Due to (centia or as e conseq consequences						
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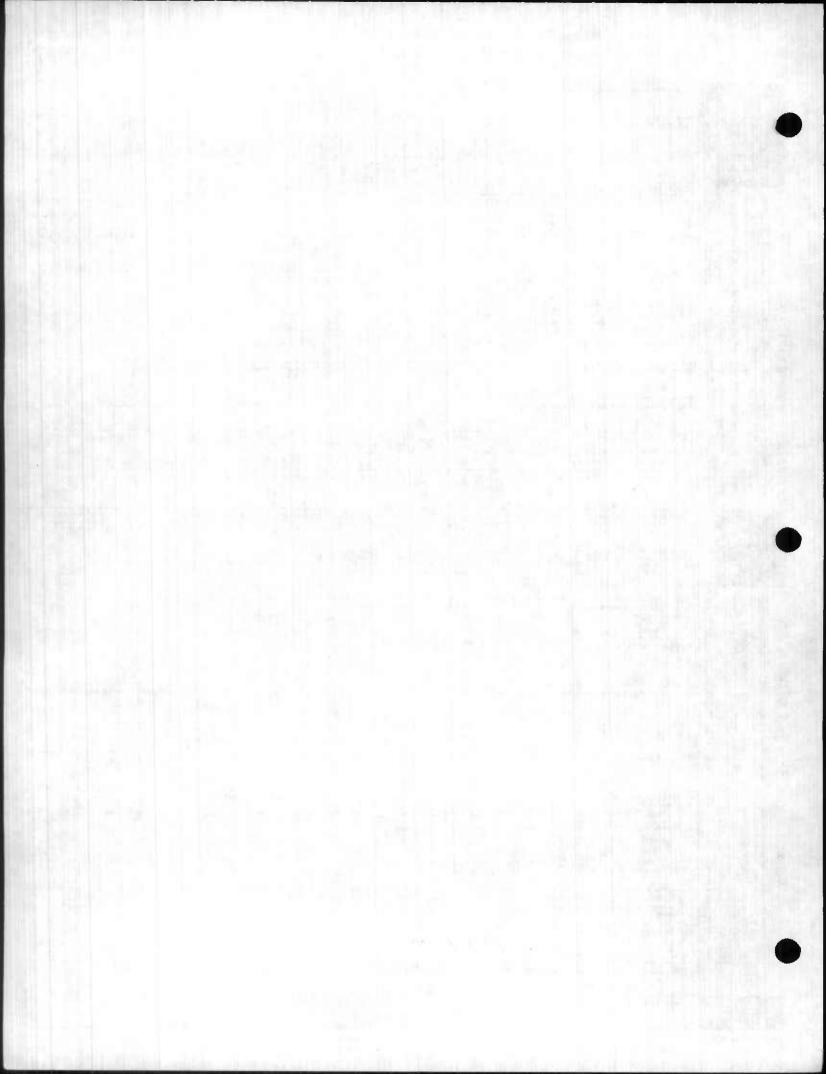
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Examin	-	4e. Facility Neme (If not institution, g	give street end number)			4b. City, Town, or	Location of Deeth	4c. County o		
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uneral			. Sex 7. A	ge (In yrs. last	M	Under 1 Year onths Days			Year)	9. Birthplece (Country)	
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Offin Offin	Director	MD Howa	c a	با	aurel						
5 8		10e. Street end Number			1	10f. Zip Code		1	0g. Citizen of WI	hat Country?	
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llen Der	5	11. Marital Stetus	12. Wes Decedent	?	If Ye	s Decadent of es, specify Cul	pan, Mexican, Puei	Specify Yes or No- to Rican, etc.)	Bleck	- American in , White, etc.	dien,
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nportant: ny injury o 058.		21. Signature of Funeral Servica Lic	anset		22. Na	ame end Addr	ess of Facility	onaldson	Funeral	Home,	P.A.
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State of Maryland / Department of Health and Mental Hygiene

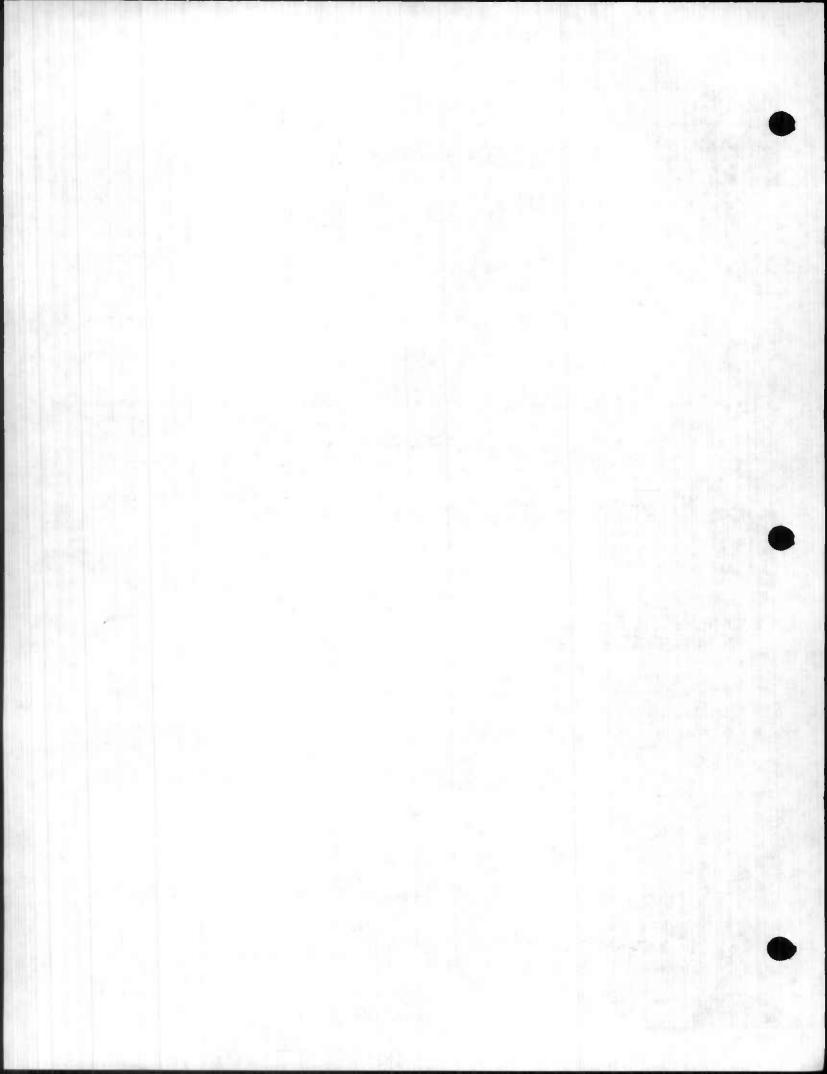
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			1. Decedent's Nem	e (First, Middle,	Last)	M. C. C.	20.00						2. Dete of D		Vana	3. Tin	ne of Deeth
	Physicia		Car1	Wilso:	n RIDDE	ER							Month Sept.	Day 13. 2	Year 000	23:	10
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				son Scho)akla			arret		
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			Usuel Residence o	f Decedent							-						
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	5 6	Director	10e. Street and Nu	mber					10f. Zip	Code				10g. Citizen o	Whet Cou	ntry?	
	ilied within 72 hours after death with the Maryland Hygiene. Hydiene. The Table of 28e-f show ent, the Medical Examinat must be notified at	<u>m</u>	948 Mas	on Scho	ol Road					- 1	21550			U	SA		
	8 EE	Funeral	11. Meritel Stetus			cedent Ever	in U,S.	13. Wa	s Dece	dent of I	Hispanic Or	igin? (Sp	ecify Yes or N Rican, etc.)	o- 14. Ra	ca - Ameri		en,
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0 :	d other	Be	17. Father's Neme	(First, Middle, La	ist)						18. Moth	er's Name	e (First, Middle	e, Maiden Sume	me)		
au		8	Ernest		F	Ridder					Doro	thy			Baker		
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	C T N F		Susan C.	Piper/	Daughter	1	56	0 Ja	aspe	r R	iley H	Road,	0akla	nd, Mar	yland	215	50
9	other		20e. Method of Dis	position		2	b. Plece of I	Dispositi	ion (Nai	me of			Dete	20c. Location			
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			23a. Pert1. Enter t shock, or hee	ert feilure. List or	nly one cause on	eech line.	000th. D0 110	,, 0,,,0,					o			Interva	al Between end Deeth
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	/Medical		Immediate Cause disease or condition	(Final	ath	neros	clero	tic	Ca	ardi	iovas	cul.	ar dis	sease		10 v	r
	Examiner		resulting in death)		θ		to (or as a co			-					1		
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	and and i-tra	×	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nditions, nmediete		Due	to (or es a co	nseque	nca of):						1		
Š	Sien Surie		Cause (Disease or	erlying													
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ם י	death e atter	Physiciar											1				
9	t the d	20	Pert II. Other signif	ficant condition	contributing to	death but no	t resulting in	the unde	erlying o	cause gi	iven in Part		23b. Did	tobacco use d	ontribute	to the ca	ues of death?
	at the	F	Diahe	tes me	111+110	tun	o TT						10	Yee 2 No	3 Pro	bably	4 Unknow
ú i	es that igned t be det	by	Diabe	ces me.	LII Cus,	, cyp	e 11										
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9	has has	<u>d</u>													0	f death?	
	ate he	Completed											1	Yes 2 No	1	Yes	2□ No
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or Vital Records,		0	examiner?	No	Hospitel:	Inpatient	2□ ER/Outp	nationt	3 D	DA OI				sidenca 6 🗆 C	ther (Spec	ih)	
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	oun and	5	1 X Neturel	5 Pending	(Mo	onth, Dey Yea	ir) Inj	iury	м		ork?						
	end sath or: /	Cat	2 Accident	Investige	t ho						Yes 2						
DIVISION	D of d	Ě	3 ☐ Suicide 4 ☐ Homicide	determin	ed 289. Pie	ca of Injury - ding, etc. (S)	At home, ferr	n, street	t, fector	y, office				(Street end Nur own, Stete)	nber or Rui	ral Route	Number,
5	ial or Attending Physis effer death. I Director; After this ed in by the funeral d	Certification:			3011	g, 5.0. (O)	,										
			29e. Certifier	1X) Certifying	Physician: To th	ne best of my	knowledge.	deeth or	ccurred	et the ti	ime, date er	nd plece.	end due to the	e ceuse(s) end	manner es	steted.	
-	To the hospital or Atlanding P within 24 hours effer death. To the Funeral Director: Affert completely filled in by the funeral	Medical	(Check only one)		aminer: On the												use(s)
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	.12			Jank	100	Killi	ress	1	L	300	135			09-1	4-00		
1	TIVA	-	30. Name and eddr	ess of person wh	no completed car	use of death	(Item 23a) (T	vpe. Pri	int)								
2	4,		Donald					*			D		0-1-1				
								ме	mor	lal	Dri	ve.	Uakla	and, M	0_21	050	
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State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 0 4 8

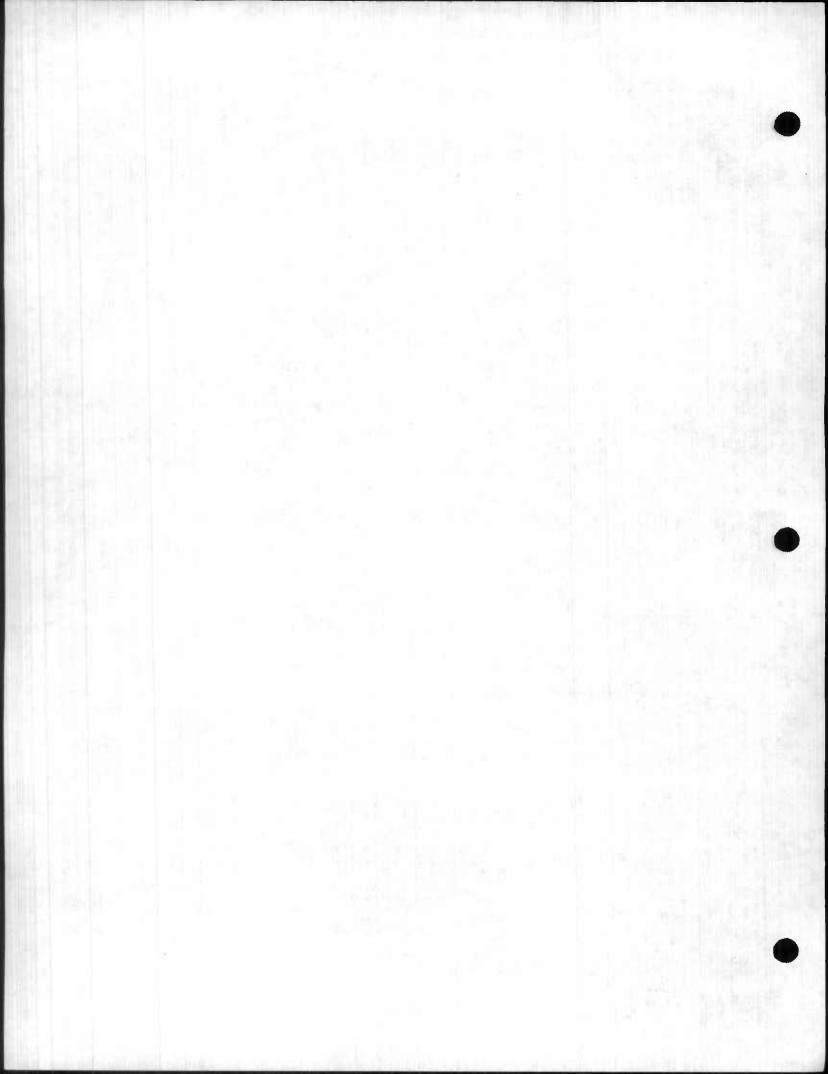
			Certific	cate of	Death	R	eg. No.	02040	
12.4	1. Decedant's Nama (First, Middle, Last)	AND THE		The second	2. Date of Deat Month		3. Time of De	eath
Physician	James J.	Sulliva	n			Sept. 2	20, 2000	7:30 P	M.
/Medical Examiner	4e Fecility Neme (If not institution, give				4b. City, Town, or	Location of Death	4c. County of		
1.4	Manor Care Potoma	ıc		19-11	Potomac		Montg	omery	
Funeral	5. Social Security Number 6. Se		asi williamy	Inder 1 Year oths Days	If Under 24 Hrs Hours Min		Year)	Birthplece (State or Fi Country)	oreign
Director	577-05-7912	□M 2ÅF 97	Yrs.		110010	Jun. 6,	1903 W	lashington,	DC.
D >	Usuel Residence of Decedent 10a. Stete 10b. County	10c City	, Town or Location	2				10d. Inside City I	Limite
ahor ahor					Self to a			1 Yes 2	
Pecto office	D.C. N/A		Washingt	On, D.	G.	- 4	0g. Citizen of W	21.	
With World			10	1. Zip Cooa	20016		U.S.		
eral	4829 Upton St. NW.	12. Was Decedent Evar in U,S	S 13 Was F	Decedant of H		Specify Yas or No-		- Amarican Indien,	-
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. To Be Completed by Funeral Evantment must be notified at once. To Be Completed by Funeral Director	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yas 2 No If Yes, Give Yeer or Detes:		specify Cub es 2∏ No		Specify Yas or No- to Rican, atc.)	Bleck	White, etc.	
hour hour	15. Decedent's Edu		16a. Decedent's	Usual Occur	pation		16b. Kind of Bus	siness/Industry	
be filed within 72 ho tal Hygiena. I other than 'natur event, the france. Be Completed	(Specify only highest grad	le completed)	(Give kind o	of work dona OT use retire	during most of wo	orking	100.11110.01.00	,	
with with the the	Elemantery/Secondary (0-12)	College (1-4or 5+)	Self E	mplove	ed		Photo F	Processing	
d 2 should be filed within 72 hours of the and Martial Hygiens of the marked other than "natural", or treumetic event, the Manicel Exam. To Be Completed by F	17. Fether's Nema (First, Middle, Last)		0011			me (First, Middle, I			
id be ked of cev	James Aloysius Sul	Llivan			Mary	Frances	Turvey		
shou nd M mer umet	19e. Informent's Neme/Reletionship (T)		19b. Mailing Add	drass (Street	and Number or A	lural Route Number	City or Town,	Stata, Zip Code)	
alth a	Mary S. Mann -	Daughter	4829 Up	ton St	. NW., W	ashington	n, D.C.	20016	
wernit. Pagas 1 an Department of Haal Important: If Item 2 Iny injury or other Ince.	20e. Method of Disposition	CA	ece of Disposition	(Name of	C0)	Date	20c. Location - 0	City or Town, State	
Page nent: M iny or	1 N Buriel 2 □ Cremetion 3 □ F 4 □ Donetion 5 □ Other (Specify)		dar Hill	Cemet	ery 9/2	5/2000	Suitland	i, Md.	
Departm Mporta any inju	21. Signature of Funerel Service Licans				-	speh Gaw	ler's So	ons, Inc.	
SSESS	Thomas &	2 know low bear	5130	Wisc.	Ave. NW	., Washi	ngton, I	o.c. 20016	
	23a. Pert1. Enter the disease, or complishock, or heart leiture. List only of	licetions that caused the deeth.	. Do not entar the	mode of dyi	ng, such es cardia	c or respiratory err	est,	Approximete Intervel Between	200
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rificate be executed on physician and a set the burial-transit	Sequentially list conditions,	D	es e consequence	e ol):	1145				
Ministration of the same of th	Sequentially list conditions, if any, laading to immadiate cause. Entar Underlying Ceuse (Diseese or Injury	•							
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artific Jing p		d							
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at the death ce dby the attendi	Pert II. Other significant conditions con	ntributing to death but not resu	Iting In the underly	ing cause gi	ven in Pert I.			tribute to the cause of o	
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le law requires that the death cartificate be executed a has been signed by the attending physician and tge 2 should be datached for use as the burial-transit ompleted by Physician/Medical Examir						24a. Wes 6	n autopsy	24b. Wara eutopsy find	dings
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The law require tata has been single 2 should Completed							777	of death?	
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Attending ir death. Attending by the fune iffication	2 Accident Invastigation 3 Suicide 6 Could not be determined	28e. Place ol Injury - At hor				28f. Location (S	traat and Numb	er or Rural Routa Numbe	er,
Later of Attending Physician: 1 is after death. In Director: After this cartification by the funaral director, p Certification: To Be C	4 Homicide	building, etc. (Specify,)			City or Tow	n, State)		
To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this cartificate he completely filled in by the funeral director, page Medical Certification: To Be Com		stcian: To the best of my know iner: On the basis of axaminati and mannar stated.							
Me Me	29h Signature and title of certifier	Λ		29c. Licen:	se number	2	9d. Date signed	(Month, Day, Year)	
0	> Surgelle Mu	th		Da	O EES	2)	Sept.	21, 2000	
10		omploted agrees of death (tra-	22a) (Time Brief)		05570				
	30. Name and eddress of person who co	1941 320 100 20 100				MA 200	7/1		
CASAS	Sangeetha Murthy,	MD., 19504 Do		., Ge:	LMantown	, Md. 208	, ¬		
State Registrar	31. Dete filed (Manth Pay, Year), 20	00 seneva		book	1				



н	1. Decedent's Name	(First Middle I	(act)			ertificate of		2. Date of D	Reg. No.	3. Time of Dea
ian cal	Violet	Mary		Stanc1	Liff			Month Septem	nber 24,	Year 2000 6:00 an
ner	4a Facility Name (If n	not institution, g	give street and nu	um <i>ber</i>)			4b. City, Town,	or Location of Dea	4c. County	of Death
	Springbroo	ok Adver	ntist Nu	irsing 8	Reha	.b.	Silver S	Spring	Montge	omery
100	5. Social Security Nur	mber 6.	. Sex	7. Age (In yrs.	lest birthda	y) If Under 1 Yeer Months Days			lirth	Birthplace (State or Fo Country)
	213-40-657	74	1□M 2፟∭F	105	Yrs.	Months Days	Hours M	Aug 1	0, 1895	England
	Usual Residence of D					1.	1		,	
	10a. State	10b. County		10c. Ci	ty, Town or	Location				10d. Inside City Li
0	Maryland N	lont com	0.2017	Cil	lver S	nrina				1 ☐ Yes 2 ☐
Directo	10e. Street end Numb		ely	211	rver p	10f. Zip Code			10g. Citizen of V	Mhat Country?
ā	100. Street and rediffe	761				101. Zip 0000			Tog. Oitizen of v	what Country?
by Funeral	314 North	vest Dr	ive			20901			USA	
ne	11. Marital Status		12. Was Dec Armed F	cedent Ever in U),S. 13	Was Decedent of If Yes, specify Cut	Hispanic Origin?	(Specify Yes or Nerto Rican, etc.)		e - American Indian, ck, White, etc.
2	1 Never Married	d 2 Married	i 1 ☐ Yes	2 No		1□ Yes 2X No		,		
	34 Widowed 4	Divorced	If Yes, G Year or I			TLI Tes ZAINO	Specify:		Specify	White
		5. Decedent's I			16a. Dec	cedent's Usual Occu	pation		16b. Kind of Bu	usiness/Industry
			grade completed)		(Giv	ve kind of work done DO NOT use retire	during most of ved)	vorking		
1	Elementary/Second	dary (0-12)	College ((1-4or 5+)	Hama				O II	
	17. Father's Name (F	iret Middle La	et)		поше	maker	18 Mothor's N	lame (First Midd	Own Hor	
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	James Will	Liam Br	ight				Alice I	Maud Bro	ok	
	19a. Informant's Nam	ne/Reletionship	(Type, Print)	Grand-	19b. Me	iling Address (Stree	t end Number or	Rurel Route Num	ber, City or Town,	Stete, Zip Code)
	Lawrence I	David S	tancliff			9 Gideon	Street.	Bowie,	MD 2072	0
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	1 🖾 Burial 2 🗆	Cremation 3		I State						
	4 ☐ Donation 5	Other (Spec	cify)	RC	ock Cr	eek Cemet	ery	9/27/00	Washin	gton, DC
	21. Signature of Fund	eral Service Lio	ensee n			22. Name end Addr Francis J	ess of Fecility	- E	al Uoma	Tena
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	23s. Paryl. Enter the shock, or heart	disease, or co	omplications that ly one cause on	caused the dear		500 Unive	rsity B	Lvd., W,	Silver	Spring, MD 20
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DHMH 16 Rev 6/95

Registrar



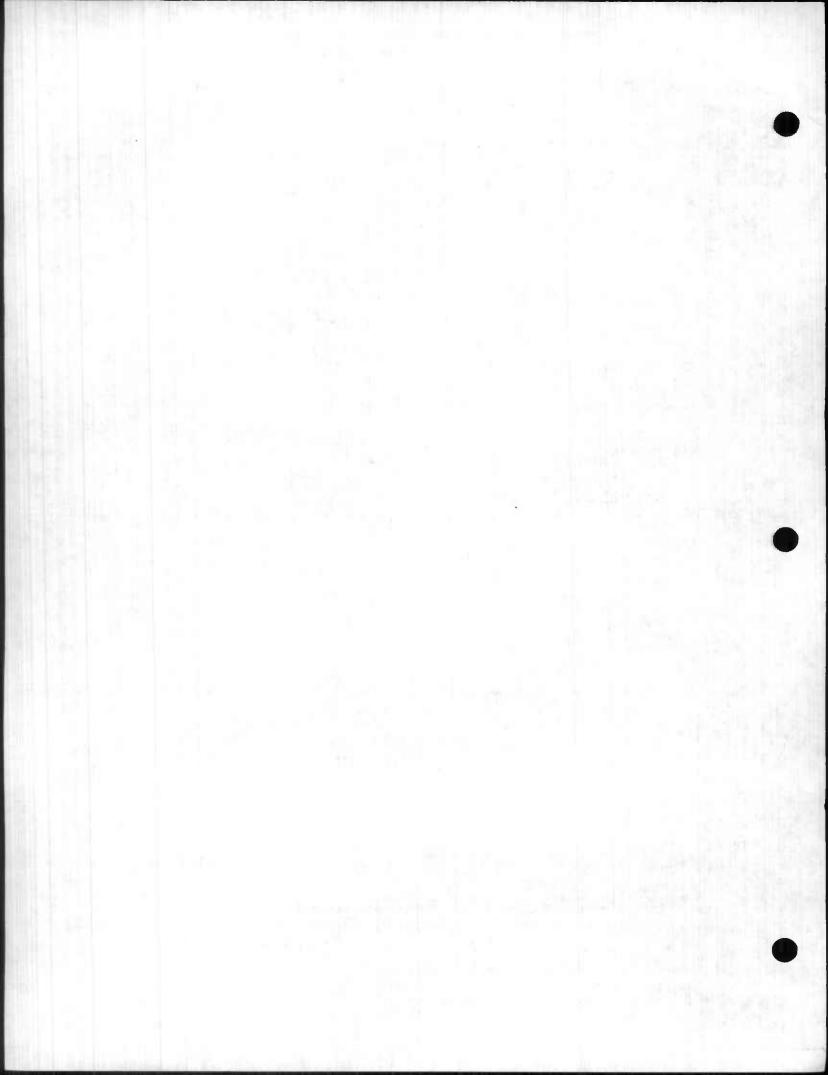
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beg No.

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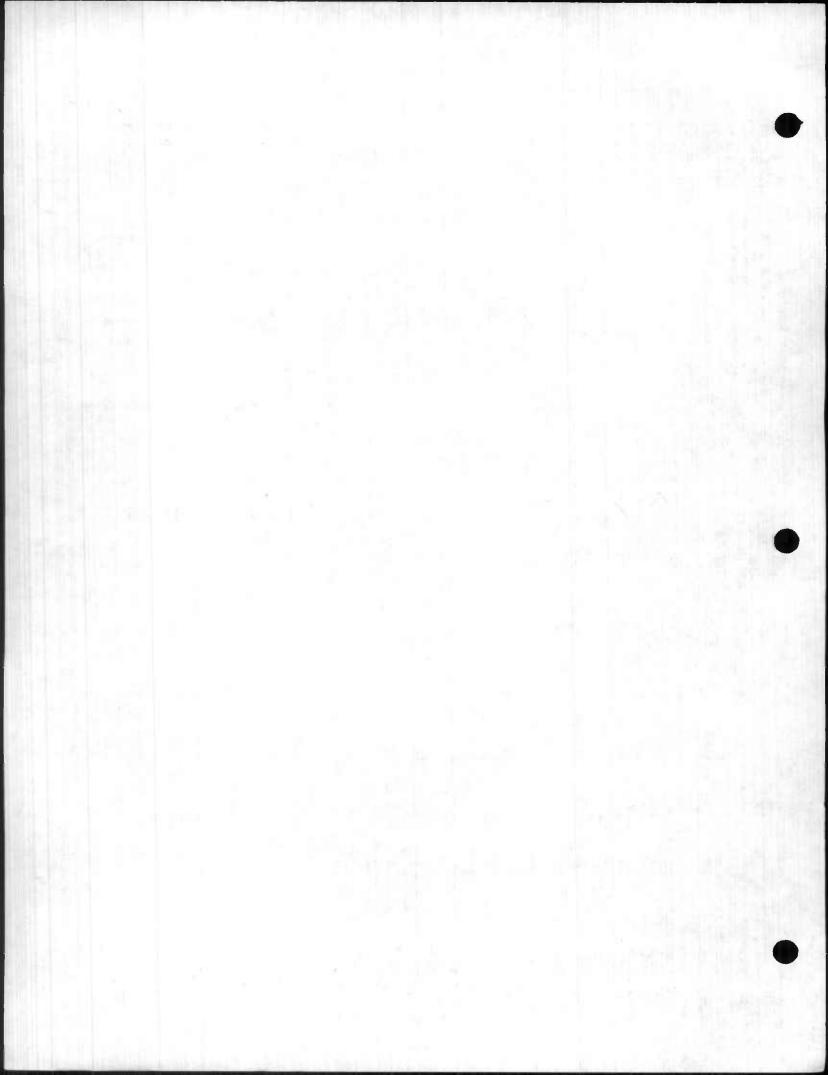
				OGILI	noate of	Death		teg. No.	
	Dhysisian	1. Decedent's Nama (First, Middla, Last	0		117		2. Date of Dea		3. Time of Death
	Physician /Medical	Marija Mar	ta Sperlins				September		
	Examiner	4a Facility Nama (If not Institution, giva	street and number)		3	4b. City, Town, or L	ocation of Death	4c. County o	f Death
	3 _ 144	Collingswood Nur				Rockvill		Montg	-
	Funeral	5. Social Security Number 6. Sa			If Undar 1 Yaar Vlonths Days		8. Data of Birt (Month, Day	Year)	Birthplaca (Stata or Foraign Country)
	Director	182-28-0311 Usual Rasidence of Decedant	JM 2XF 92	113.			March 23	, 1908	Latvia
	and and	10a. Stata 10b. County	10c. City,	Town or Loca	tion				10d. Inside City Limits
	f ah	Maryland Prince Ge	orge's Chev	verly					1 □ Yas 2 No
	the root	10e. Street and Number	orge b one.	CILI	10f. Zip Coda	T-in-		10g. Citizan of WI	hat Country?
	Sa or	2811 Crest Avenue			20785-	2965		United S	tates
	ifter death with the Mar r items 23s or 28s-f s inserment be notified Funeral Director	11. Marital Status	12. Was Decedant Evar in U,S.	. 13. Wa		Hispanic Origin? (Sp pan, Maxican, Puerto			- American Indian,
0	Fur Fur	1 ☐ Never Married 2 ☐ Married	Armed Forcas? 1 ☐ Yas 2 ☒ No				Hican, atc.)		, Whita, atc.
21215-0020	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "natural", or items 23s or 28s-f show avent, the testeral Tester or must be notified a Be Completed by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	If Yas, Giva Year or Dates:	10]Yas 2⊠No	Specify:		Specify:	White
5-0	ed within 72 ho tygiene. The test and it, free test and it.	15. Decedent's Edu (Specify only highest grad		16a. Decedar	nt's Usual Occu	pation during most of work	ina	16b. Kind of Bus	inass/industry
21	c 1.4 -	Elementery/Secondary (0-12)	College (1-4or 5+)			during most of worked)			
	filed within Hygiene. ther then and, the ten	12		Homen	naker	T	4000 . 44144	Own Hon	
and	Mai H	17. Father's Name (First, Middle, Last)				18. Mothar's Nam		Maidan Sumame	,
Yie	2 should be filed within end Mental Hygiene. Is marked other than surratic avant, the Mental To Be Comp		ridenbergs-Ansl			Not Avai			
Maryland	is m	19a. Informant's Name/Relationship (7)				t and Number or Rui			
	1 end 2. Health er mm 27 is ther trat	Talivaldis Ivars		2811 C			Data		20785-2965 Dity or Town, Stata
10	Pages 1 on the mart of He mart. If the mary or other	1 ☐ Burial 2 🖾 Cramation 3 ☐ F	Ramoval from Stata cen	matary, crama	tory or other pla		ct. 1,	200. Eduation - C	nty or rown, Stata
tim	t. Pa tmer tent: jury	4 Donation 5 Othar (Specify)			rematorio		2000	Bethesda	, Maryland
Baltimore,	permit. Pages 1 end 2 should Deperment of Health and Men Important: If item 27 is marke any injury or other traumatic ang.	21. Signature of Funaral Sarvice License	M00672	Robe		imphrey Fund			e, Inc. aryland 20850-2805
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	oerificate be axecuted adding physicien and use as the burial-transit	Sequentially list conditions,	Dua to (or a						
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00	been signature should been signatured should been signatured should be shoul						perfo	rmed?	available prior to completion of cause of death?
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<u>a</u>	certificate rector, pag	25 Was assa referred to medical				00 814 8	1 🗆 '	**	1 ☐ Yes 2 ☐ No
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	within 2 To the compla	29b. Signature and titia of certifiar	and the same of th	4.00	29c. Licar	sa number		29d. Data signed	(Month, Day, Year)
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		30. Nama and addrass of person who con Sameh A. Aly, M.D.				10 #230	Caithar	chura M	Maryland 20877
	State		32. Registrar's Signatu	- and the			Jarchel	anurg, r.	iarytanu 200//
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State of Maryland / Department of Health and Mental Hygiene

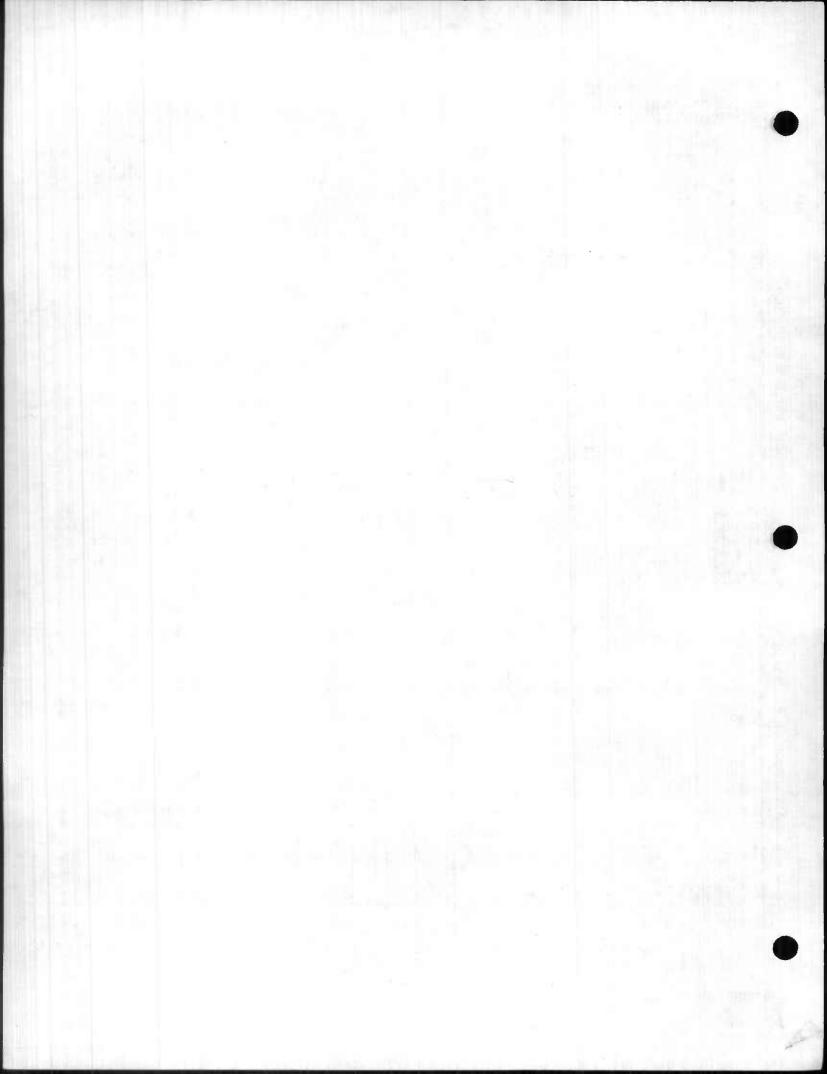
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/Medical	Ruth L. Sr	nith								_	per 23,		1:05 PM			
Examiner	4a Facility Nama (If not institution 13208 Rippling							4b. City, To Silver		ocation of Deeth	1	y of Death	v			
uneral	5. Social Security Number	6. Sex	7. Aga (In yr.	s. last birti		If Undar	1 Yaer	If Under:	24 Hrs.	8. Dete of Bird (Month, De			place (Stata or Foreign ntry)			
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	Usuat Residence of Decedent 10e, Steta 10b, Count	v	10c. C	City, Town	or Locat	tion		~				1	10d. Inside City Limits			
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Directo	10e. Street and Number					10f. Zip	Coda				10g. Citizen of	What Cour	ntry?			
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	Wanda L. Kirk/	Cousin	0.01					Kun,	Ljar	nsville						
)	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removat from	n Stata		y, cramet	tory or o	ther pla		S	ept. 26,	20c. Location					
	4 Donetion 5 Other (Pa	arkla				L Park	-	2000			aryland			
8	21. Signatur Funerat Service	Licensee			Rot	bert	d Addra	Pump n	rey	Funera:	l Home/	Rockv	ille, Inc.			
	Kutt	we	M00	0198						Avenue 1 20850						
as the bunal-transit Adical Examiner	Sequentially list conditions, if eny, leading to immadiata ceuse. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last	b	Dua to	(or as a c	consequa	ance of):					J					
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10	1 Yas 2 No	Hospital: 1	Inpatient 2	□ ER/Out	tpatient	3 DC	Ot Ot	ner: 4 🗆 Nu	rsing H	oma 3 Rasi	dence 6 □O	ther (Speci	ity)			
		27. Mennar of Death Naturel 5 Pending 28a. Data of Injury (Month, Day Year) 28b. Time of Injury Work?										28d. Dascribe how injury occurred				
Certification:	3 Suicide 6 Could 4 Homicide	mined 288. Pla	ce of Injury - At Iding, atc. (Spec	home, far	rm, straal	t, factory	, offica			28f. Location (City or To		nber or Run	al Routa Number,			
edicai C	29e. Certifiar Certify (Check only /2 Medica one)	ing Physician: To the Examiner: On the	basis of axamir	nowledga, nation and	, daeth od d/or invas	ccurrad stigation,	at tha ti	me, data an opinion, daa	d ptece, th occur	and dua to tha red et the tima,	causa(s) and n data and place	nannar as s	stated. to the ceusa(s)			
ĕ	29b. Signature and titta	and me	enner stete	-		290	. Licens	se number			29d. Data sign	ad (Month	Day, Year)			
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	30 Name and address of perso	W11	They	7	Iype, Pri	Int)	1	nce '	47	1 dy	11.0	imi	NP 3188			
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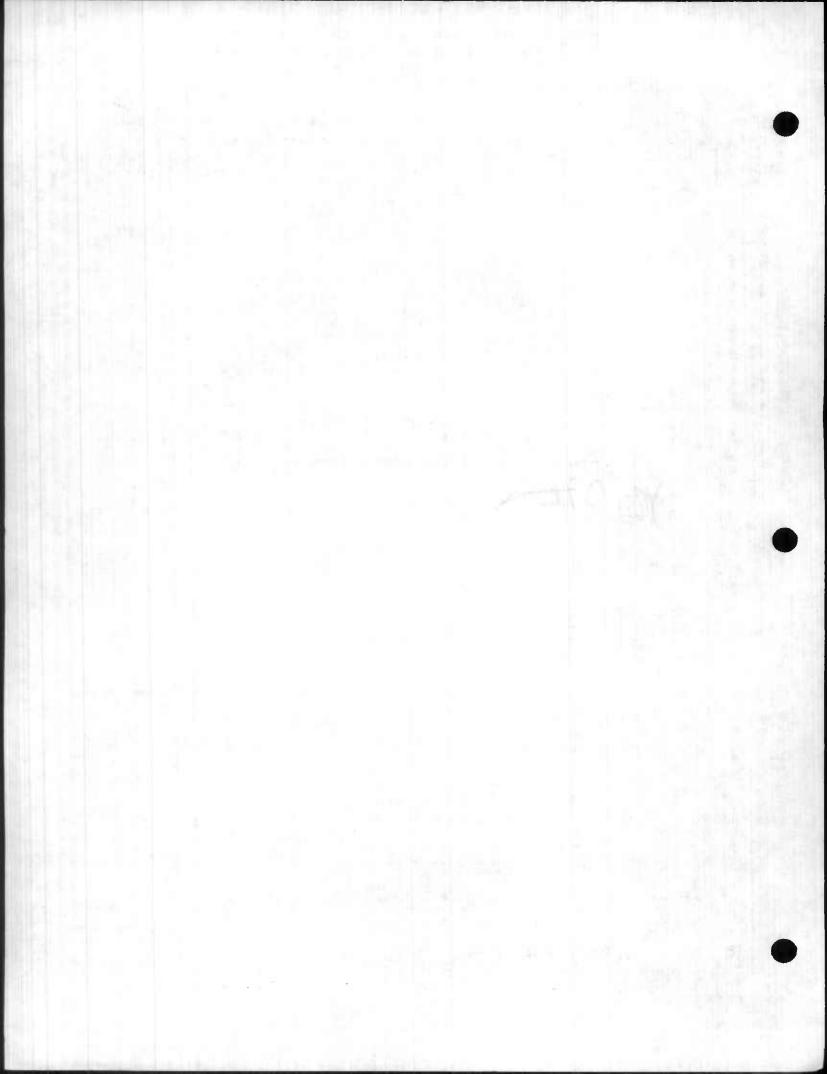


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day **Physician** Marie Ethel Smith September 19, 2000 6:50 AM /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Holy Cross Hospital Silver Spring Montgomery | H Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 1923 | Washington, DC 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** 1□M 2対F Yrs 216-58-6939 Director Usual Rasidance of Decedant 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland | Montgomery Silver Spring 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 12707 Spring Tree Drive 20904 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 N Merried 21215-0020 1 ☐ Yes 2 ☑ No Specify. Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Peges 1 and 2 should be filled Department of Health end Mental Hyg Important: if Itam 27 is marked other any Injury or other traumatic avant, Baltlmore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Surname) Be Harry W. A. Wellens Mary Preuss 19e. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Albert Smith / Husband 12707 Spring Tree Dr., Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Plemoval from State 4 Donetion 5 Other (Spenty) Fort Lincoln Cemetery 09/23/00 Brentwood, Maryland 21. Signature of Funeral Service Lice 22. Nama and Address of Fecility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland Enter the disasse, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, for heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Anterior Myocardial Infarction Examiner Due to (or es e consequance of): Examiner Coronary Artery Disease The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Disease or injury that Initiated events rasulting in death) Last Due to (or es e consequence of). and Diabetes P.O. Box 68760, Physician/Medical the Due to (or as e consequence of): SE esn Hypertension Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detact 1 ☐ Yas 2 No 3 ☐ Probably 4 ☐ Unknown þ Records, 24b. Wera eutopsy findings evailable prior to completion of cause of deeth? Completed 24a. Was an eutopsy pege 2 1 Yas 2 XNo 1 ☐ Yas 2 ☐ No certificate Division of Vital or Attanding Physician: director Be 25. Wes case raferred to medical axaminar? 26. Place of Deeth (Check only one) Hospitel: 1 ☑ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this 28a. Data of Injury (Month, Day Year) funaral 28d. Dascribe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending in 24 hours after death.

Ne Funeral Director: Aftipletely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datarmined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide Hospital Medical Examiner: On the basis of avamination and the immedical Examiner: On the basis of avamination and the immedical Examiner: On the basis of avamination and the immedical Examiner: On the basis of avamination and the immedical Examiner: On the basis of avamination and the immedical Examiner: On the basis of avamination and the immedical Examiner: On the basis of avamination and the immedical Examiner: On the basis of avamination and the immedical Examination and the immedical 29a. Certifier completely Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29 License number 8 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Aaron Kenigsberg, M.D. 10313 Georgia Ave., #307, Silver Spring, Maryland 20902 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State SEP 2 5 2000 sacker Registrar

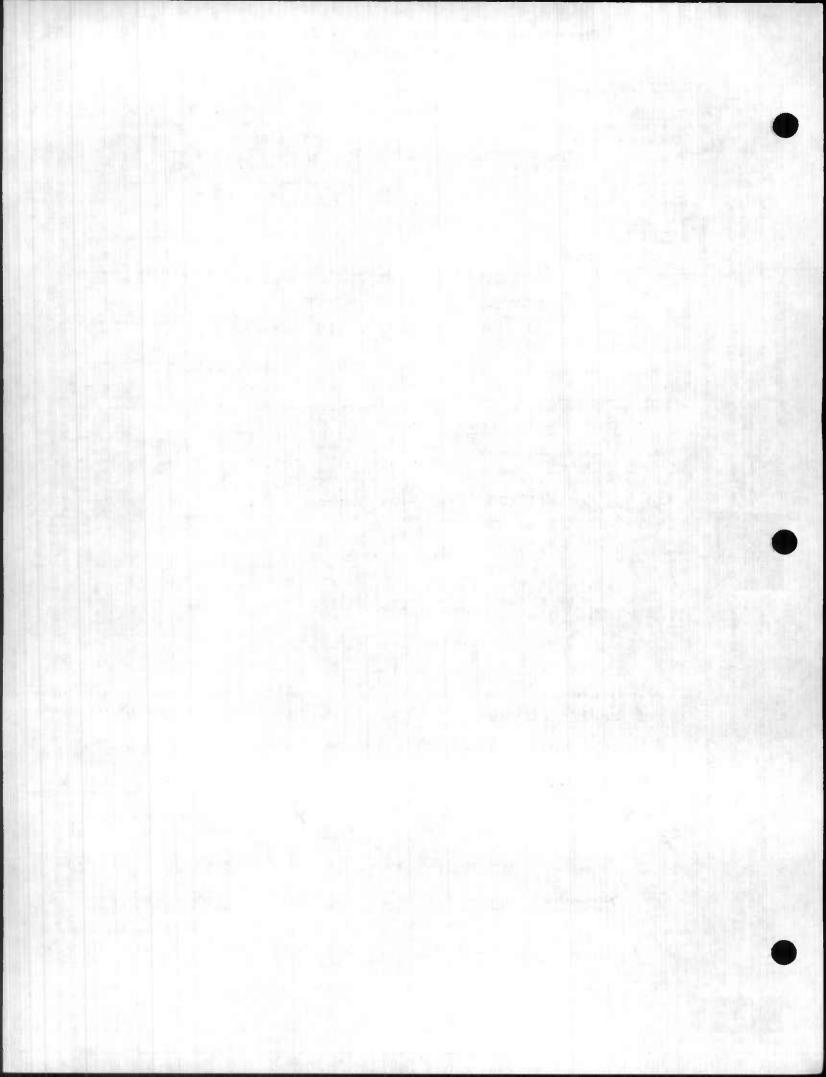


					Cer	tificat	e of	Death		8	leg. No.			00	
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Physicia	_	Marga	ret L.	. S	mith				Se	eptemb	er 20,	2000	10:40	0AM	
/Medic		4e Facility Neme (If not institution, give	re street end number)					4b. City, To	wn, or Local	tion of Death	4c. County	of Deeth	1		
Examine	er	Mariner Health o		Shrino				Silve	r Spri	nø	Montg	omery	,		
				e (In yrs. last i	birthdev)	If Unda		If Undar	-	Date of Birth		-		or Foreign	
Funeral Director		219-34-8660	1□ M 2∏F	75	Yrs.	Months	Deys	Hours	Min.	(Month, Dey	0, 1925	Kans	placa (State on ntry) a.S		
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No M	5	Maryland Montgome								- M					
permit. Peges 1 and 2 should be filled within 72 hours after death with the Manyland Depertment of Health and Mential Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injuryor other traumatic event, the Medical Exercises must be notified at odds.	Funeral Director	10e. Street and Number				10f. Zip					10g. Citizen of What Country? United States				
23a	<u>a</u>	18403 Fairweathe	r Drive												
de ma	Ine	11. Marital Status	12. Wes Decedent Armed Forces?	 Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Sp. If Yas, specify Cuben, Mexican, Puerto 				igin? (Specif n, Puerto Ric	y Yes or No- can, atc.)	14. Rad Blad	ck, White,				
d within 72 hours after piene. Triben "netural", or H	E	1 Never Merried 2 Merried	1 ☐ Yes 2 ☑ I	1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify:							Specif	. Whi	ite		
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2 shx and is m		19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Ste													
1 and 2 Health em 27 i		Kathleen S. Jord	an / Daugh	iter 1	8403	Fair	wear	ther	Drive,	Olney	, Mary	land	20832	2	
of He		20a. Method of Disposition		20b. Place ceme	of Dispos	sition (Ne	me of other ple	ce) Gate		Date	20c. Location	City or To	wn, State		
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permit. Peges 1 ar Department of Hea Important: If Item 2 any injury or other price.	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Robert A. Pumphrey Funeral Home / Rockville,										_			
Depermine Depermine Important in the Concession of the Concession		Who ! !	1											0.000	
	-	M00689 300 West Montgomery Avenue, Rockville, Maryland 2085													
		23a. Part Blood the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deetl													
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1940	-			Due to (or es	e conseq	uence of)									
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delificate certificate rector, pag	BeC	25. Wes cese referred to medice!		-				26 Plac	e of Deeth /	Check only o					
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or A after Direction by	Ē	4 ☐ Homicide determined	building, et	c. (Specity)	, 101111, 0111	001, 100101	y, oo			City or Tow					
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		29b. Signature and title of certifier	1 0			29	o. Licans	se number		29d. Date signed (Month, Dey, Year)					
[8		MUM	ofert			I	098	34	V-E	September 21, 2000)	
		30. Neme and address of person who										7-31			
		Barry N. Rosenba	um, M.D. 3	720 Far	rragi	ıt Av	enue	e, Ker	nsingt	on, MD	20895)			
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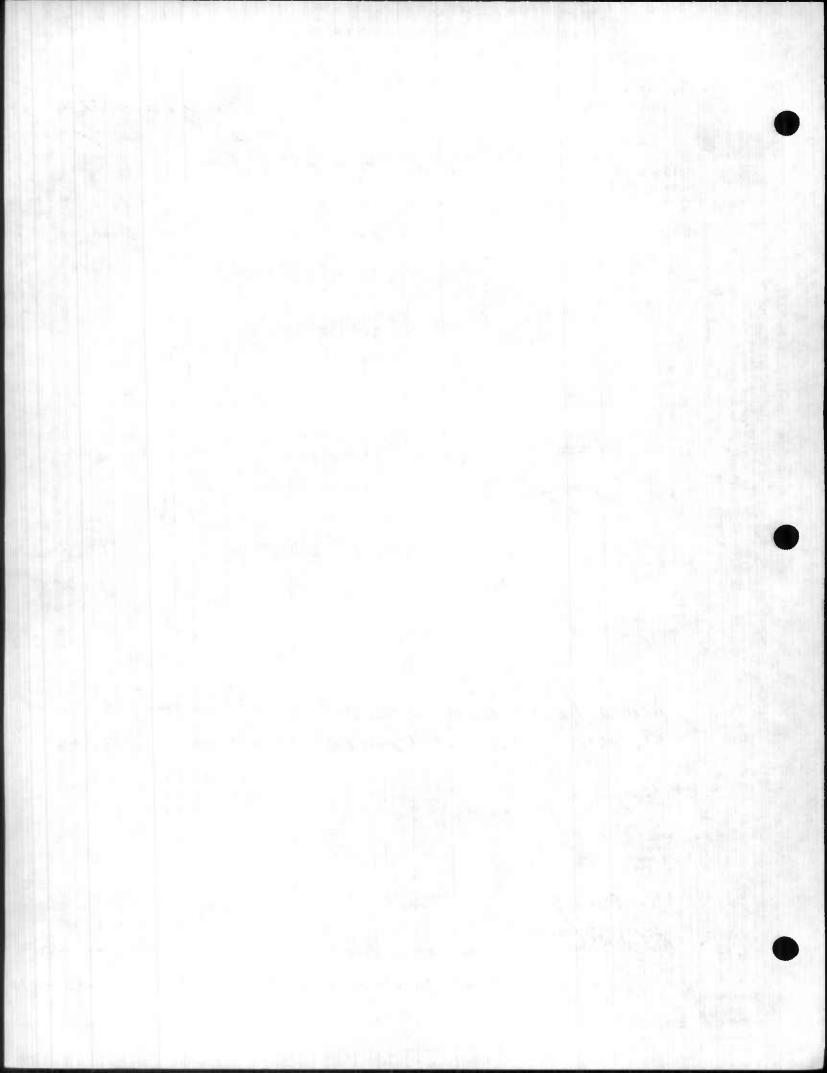
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/Medical Examiner	4e Facility Neme (e street and number)					b. City, To	wn, or Lo	cation of Death	4c. Count	of Death			
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Depertment of important: If it sany injury or pace.	21. Signature of F	oneral Bervice Dec	1800	1			s of Facilit	gwardt Funeral Home, P.A. i11 Rd. Beltsville, Maryland 2070							
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State of Maryland / Department of Health and Mental Hygiene 00 32055

	Certificate of Death Reg. No.										
Physician /Medical		haan					b City Tay		MBER 21		3. Time of Deet 1234
Examiner	4e Facility Neme (If not institution SHADY GRO			SPIT	ral .	4	b. City, Town, or ROCKV	ILLE	M		GOMERY
Funeral Director	5. Sociel Security Number 215-06-6200	6. Sex 1 □ M 2 ☑ F	. Age (In yrs. last) 48	birthdey) Yrs.	If Under Months	1 Yeer Deys	If Under 24 Hrs Hours Min.	8. Dete of E (Month, I June 2	Sirth (25, Year) 25, 1952	9. Birthp Cour Ind	olece (Stete or Forentry) Onesia
72 hours efter death with the Maryland natural, or flems 23a or 28a-f show are Examined manual to mortified at steed by Funeral Director	Usuel Residence of Decedent 10a. Stete 10b. County Maryland Montg		10c. City, To							1	10d. Inside City Lin 1 ☐ Yes 2 €
	10e. Street and Number				10f. Zip	Code			10g. Citizen of V	Vhet Cour	ntry?
am w 1 23a	26 Cinzano Cou					0878			Indone		
which the matural, or term 23a or 28a-1a. The Medical Examiner must be notified.	11. Meritel Stetus 1 ☑ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	Armed Ford	2⊠ No		Wes Decedent Yes, special Yes 2		ispanic Origin? (S in, Mexican, Puer Specify:	ipecify Yes or f to Rican, etc.)		k, White,	ean Indien, etc. nesian
natural',	15. Decede	nt's Education	16	Sa. Deced	dent's Usua	Occup	etion	rkina	16b. Kind of Bu	siness/In	dustry
	Elementery/Secondery (0-12)	est grade completed) College (1-	4or 5+)		Nanny	e retired	during most of wo	ikiliy	Child	d Care	
Mental Hy Brice of the stic event	17. Fether's Neme (First, Middle Dau Lat Siahaa						18. Mother's Na Tiang		le, <i>Maid</i> en Su <i>m</i> em itupulu	ie)	
alth end i	19a. Informent's Neme/Relation Walter Engelen								nber, City or Town, Marylan		
Department of Health and Mental Hydrens. Important: If Item 27 is marked other than any injury or other traumatic event, the Health and Item 1 once. To Be Compi	20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Neme of cemetery, cremetory or other picture) Gate of Heaven C							Dete 9/26/00	20c. Location - Silver S		
Departri Importa eny inju	21. Signature of Fugeral Service	Licensee 2	Left	1	1800 1	New	ss of Fecility Hi Hampshin	e Avenu	naldi Fun ue 20904	eral	Home
ding physician end season of seas the burial-trensit and season of	Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest	d	Due to (or es Due to (or es	e conseq e conseq	quenca ot):						13 DAY
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completed by P	METASTA	TIC UTE	MINE	C	ANC	ER		24e. We	24e. Wes en eutopsy performed? 24b. Were eutopsy evaileble prior completion of deeth?		
ate ha								10	Yes 2 No	11	☐ Yes 2☐ No
is certificate director, pag	25. Was case referred to medical examiner?	Hospital.				000	26. Plece of De	eth (Check on)	y one)		
within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be (3 Suicide 6 Could	ng 28e. Dete of (Month igetion not be pined 28e. Plece of		o. Time of Injury	М	Bc. Injur Wor 1	4 LI Nursing I	28d. Describ	sidence 6 Other how injury occurs (Street end Numbrown, Stete)	red	
within 24 hours of the Funeral completely filled	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To the base and menne	is of examinetion	lge, deeth end/or inv	n occurred e vestigetion,	et the tin	ne, date end plec pinion, deeth occ	e, end due to the	ne ceuse(s) end me e, date end placa,	enner es s and due t	stated. to the cause(s)
within 24 To the Fu	29b. Signeture and title of	anew			290		e number		29d. Dete signe	d (Month,	Dey, Year)
60	30. Neme end eddress of person	RITKAZ	ARE CO			7	030112		SEPTEMI		
State Registrar	VIRENDRA K. 31. Dete filed (Month, Dev. Year		GOO M gistrer's Signeture		Spa	uks	rcue #	301, GA	MOHENSB	UR G	MD 20

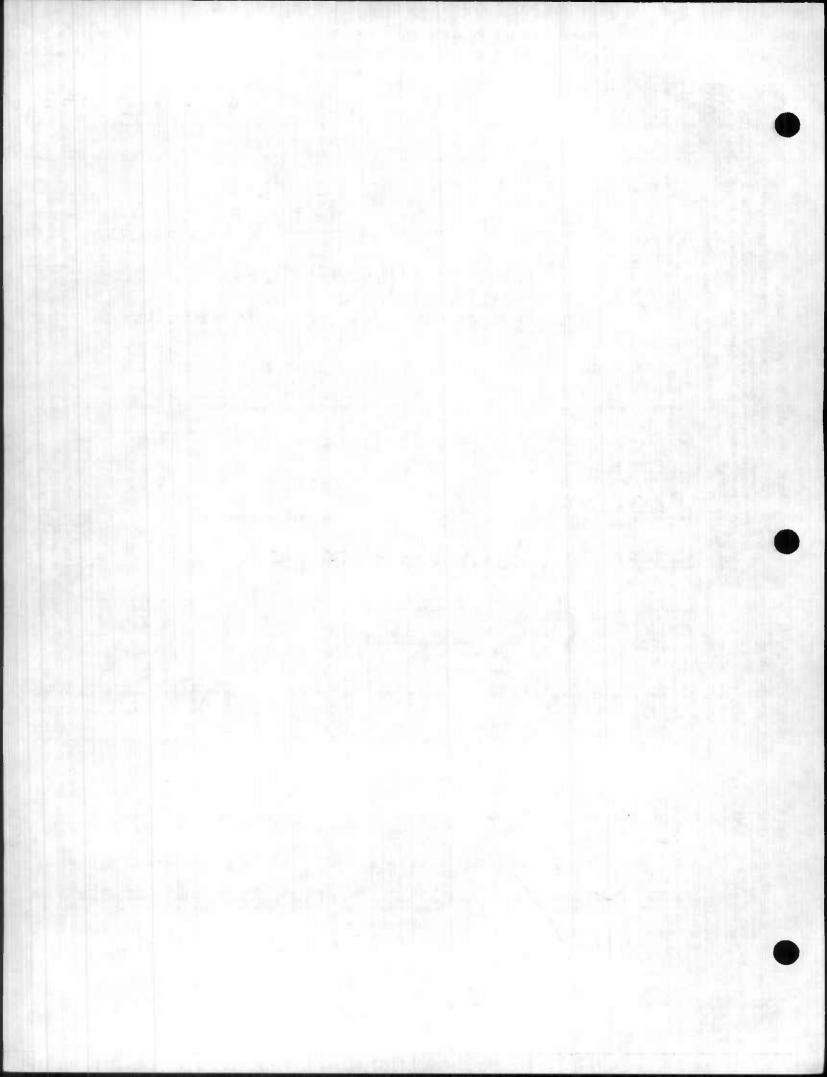


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Menth Au **Physician** 2000 NATHAN SHINDERMAN /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, giva street and number) Examiner MONTGOMERY POTOMAC 11317 BERGER TERRACE 7. Age (In yrs. last birthday) 85 Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthpleca (Stete or Foreign Country)
NEW YORK 8. Date of Birth (Month, Dey, Year) 01-21-1915 5. Social Security Number **Funeral** Days Hours 10M 20F Director 109-07-9949 Usuet Residence of Decedant 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or lients 23s or 28s-f show with the Maryta pane, r than "natural", or heme 23a or 28a-f sho the Medical Examiner must be notified at 14 Yes 2□No POTOMAC MONTGOMERY Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20854 Funeral 11317 BERGER TERRACE Wes Decedent of Hispanic Origin? (Specify Yes or No It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 X No It Yes, Give 1 Never Merried 2 Merried WHITE Maryland 21215-0020 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Yeer or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) US GOVERNMENT PERSONNEL MANAGER 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumeme) Be should be and Mental CEILA NOLOBOFF MEYER SHINDERMAN 19b. Mailing Addrass (Street end Number or Rurel Routa Numbar, City or Town, Stata, Zip Code)

20854 pur 19e. Informent's Neme/Relationship (Type, Print) Pages 1 and 2 s ment of Health an 11317 BERGER TERRACE, POTOMAC, MARYLAND . partment of Health a portant: If item 27 is y Injury or other tree JANET PINCUS/DAUGHTER Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 20e. Mathod of Disposition SEPT 26 1 ☐ Buriat 2 ☐ Cremetion 3 ☐ Removel from Stete KING DAVID MEMORIAL GDNS 4 ☐ Donetion 5 ☐ Other (Specify) 2000 FALLS CHURCH, VA 21. Signature of Fyheral Service Ligensee amy le 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intarvai Between Onset end Death Physician /Medical Immediete Causa (Finei diseese or condition rasulting in death) Examiner Due to (or es e consequença ot) Examiner as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es e consequence ot): P.O. Box 68760. been signed by the attending physician should be detached for use as the buria Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Wara eutopsy findings aveilable prior to completion of cause ot death? 24a. Wes en eutopsy performed' page 2 s 1 ☐ Yes 2 ☐ No ON No 1 Yes this certificate Physician: funeral director, 25. Wes case reterred to medicat examiner? Be 26. Placa of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas ZINO Other: Certification: To 4□ Nursing Home \$ Residence 6 □ Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury et Work? Waturet 5 Pending investigation 1 Yes 2 No 2 Accident 28t. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Plece of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D Medical Examiner 29a Certifier in: To the best of my knowledga, deeth occurred el the time, date end piece, and dua to the ceuse(s) end mannar as stated.
The basis of exeminetion end/or invastigation, in my opinion, deeth occurred at tha time, dete end placa, end due to the ceuse(s) Medical and mannar steted 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a 20 30. Neme and south MARK E16, Mo 31. Dete filed (Month, Day, Year) SEP 2 7 ss of person who completed cause of death (Item 23e) (Type, Print) Lockwood Drive #280 Silver Spring, Md. 20901 10801 Md. 32. Registrer's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent'e Name (First, Middle, Last) 2. Date of Death 3. Time of Death SHE Day **Physician** ATHERINE September 27, 2000

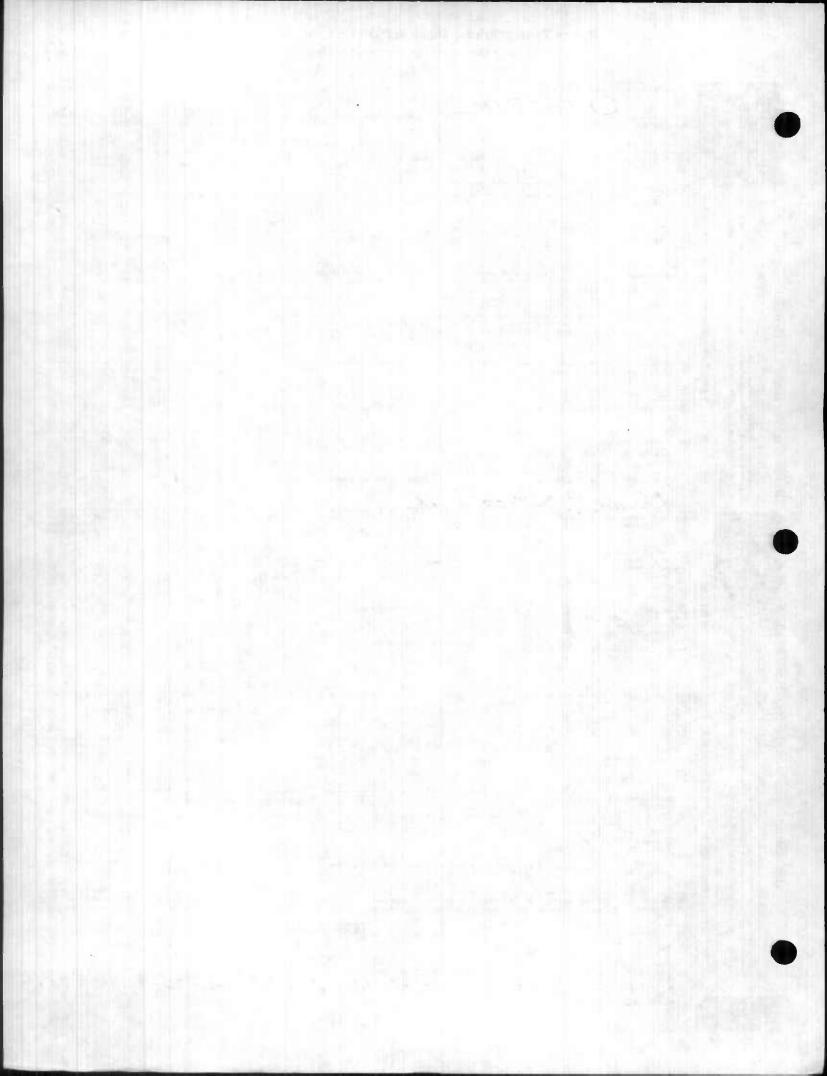
4b. City, Town, or Location of Deeth 4c. County of Deeth 2:00 A.M. 2000 /Medical 48 Facility Neme (If not institution, give street end number, Examiner Silver Spring Montgomery 3701 International Drive, Apt. 338 ocial Security Number 6. Sex - 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2QF Months Yrs. 104-14-8290 78 June 20, 1922 Director New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 10a. State 10b. County 1 Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code r Herna 23a or 7 3701 International Drive, Apt. 20906 S. Funeral 338 J. S. A.

14. Race - American Indien,
Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1X Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Merried Baltimore. Maryland 21215-0020 "natural", or 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Own Home 2 Years Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be filk Department of Health end Mental Hy Important: If Itam 27 is marked other any injury or other traumatic avent Be Isadore Feder Mary Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Judy S. Miller - Daughter 11213 Broad Green Drive, Potomac, Md. 20854 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Lawn Cemetery 9/29/2000 Pompano Beach, Florida 22. Name end Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Approximete interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart tailure. List only one cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** immediate Cause (Final diseese or condition resulting in death) SEVERE CHRONIC OBSTRUCTIVE /Medical Examiner Due to (or as a consequence of): PULMONARY OLSEASE Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 68760. Due to (or es a consequence of) Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown þ Records, 24b. Were eutopsy findings evailable prior to 24a. Wes en eutopsy performed? Completed completion of cause of death? eged 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After Division or Attending 5 Pending Investigation 1 Natural 1 Yes 2 No after deeth. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completaly filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) and manner stated. 29a, Certifier 29d. Date; signed (Month, Day, Year) 29c. License number 29b. Signatured cause of death (item 23a) (Type, Print) RAY AVE BETHESDA, MD ZOS/4 ING MD 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

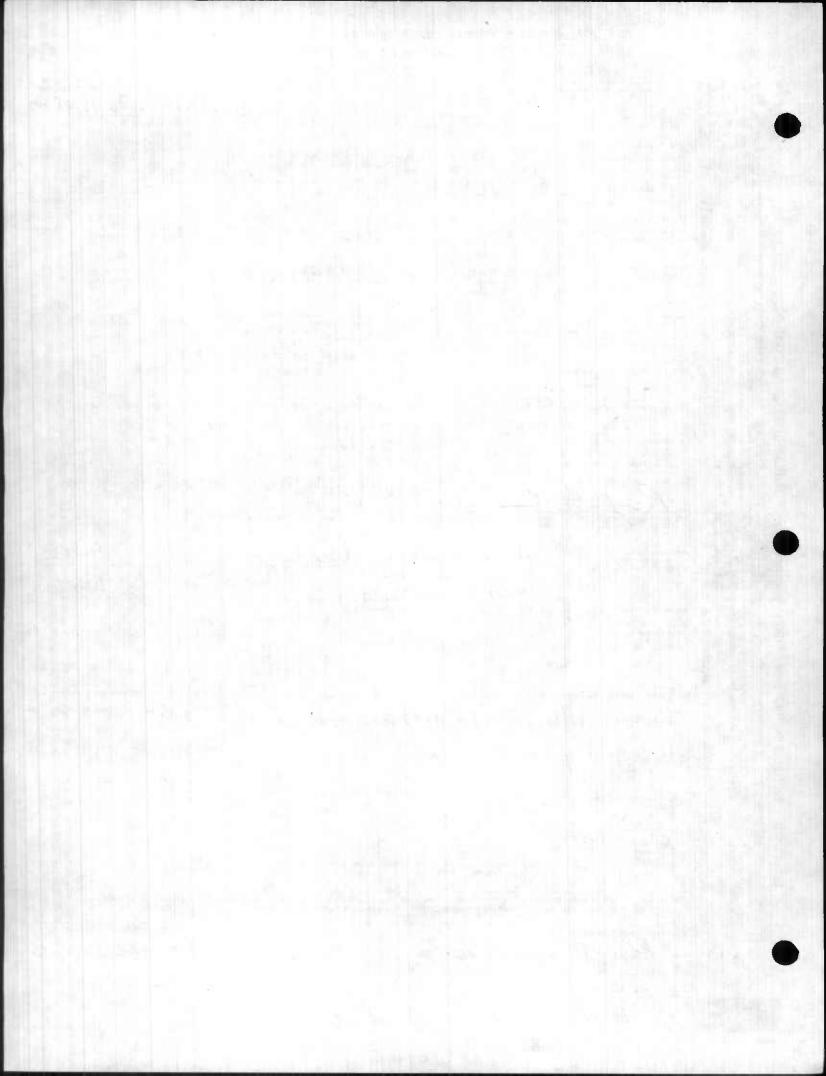


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State of Maryland / Department of Health and Mental Hygiene 00 32058

				Cer	tificate (of L	Death			Reg. No.		
Ohusisian	1. Decedent's Name (First, Middle,		U 0-11	-1					2. Date of Dea	nth Day	Year	3. Time of Death
Physician /Medical		James	H. Sali	sbury					Seplemb	424	2000	12:05 Am
Examiner	4a Facility Neme (If not institution,	give street and num	ber)			4	b. City, To	wn, or L	ocation of Death	4c. County	of Death	
	Suburban Hospit	al					Beth				gome	ry
Funeral			. Age (In yrs. la		If Under 1 Y Months D	eer ays	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h v, Year)	9. Birth	place (State or Foreign
Director	301-01-9865	1⊠M 2□F	77	Yrs.		_			March 4	, 1923		io
y .	Usual Residence of Decedent 10a. Stete 10b. County		100 City	Town or Lo	antion	_				-	1.	Od. inside City Limits
anyta ahon dat												1 ☐ Yes 2 ☒ No
Sa-f Mark	Maryland Montg	omery	В	ethesc								
th with the Maryland 23s or 28s-f show ant be notified at	10a. Sireel and Number				10f. Zip Co					10g. Citizen of		
23s					208					United		
har death v thems 23s sher mant	11. Meritel Status	Armed Ford		i. 13. V	Vas Decedent Yes, specify	of H Cuba	ispenic Ori ın, Mexicar	gin? (Sp i, Puerto	ecity Yes or No- Rican, etc.)	14. Had	ck, White,	ean Indian, elc.
D20		If Yes, Give	2 No		☐ Yes 25	No	Specify:			Specif	Wh:	ite
d b		Yeer or Dat	tes: WW I		to all a life control		-41			16h Vind of D		duetes
Maryland 21215-0020 d 2 should be liked within 72 hours at the and Mental Hygiene. T' is merical other than "haturel", or traumatic event, the Medical Exam To Be Completed by 8	15. Decedent's (Specify only highest			(Give	lent's Usual O kind of work d DO NOT use re	lone o	during mos	t of work	cing	16b. Kind of B	usiness/in	dustry
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d the fid the	Ismaa Formant								May Rose			
T Mark of Mark	19a. Informant's Name/Relationshi			10h Mailir	n Address /Si	troot			ral Route Numbe	Code)		
Magaga Ma	Agnes K. Salisb											
- 5575 - 5575	20e. Method of Disposition	ily/wile	20b. Pla		sition (Name on netory or other			, DE	thesda,	20c. Location		20817 own. State
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attimore mit. Pages 1 partment of He portant: if Hen y Injury or oth	4 Donation 5 Other (Spe		ran						2000			
Deps Impo	21. Signature of Funeral Service Li	pensee	M00198	_ /5	57 Wis thesda	CO	nsin	Aver	Funeral nue 20814-		ethe: Ch	sda-Chevy ase, Inc.
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68760, ficate be axecuted physician and as the burial-transit edical Examir	Cause (Disease or injury that initiated events resulting In death) Lest Due to (or as a consequence of):											
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Attending r death. Sector: After funally the funally fileation	1 Neturel 5 Pending 2 Accident investige		i, Dey Tear)	Injury	М		Yes 2	No				
OIVISION or Attending after death. Director: After I in by the funa	3 Suicide 6 Could no determin	200. FIECE (of Injury - At hon	ne, farm, str	eet, factory, of	ffice			28f. Location (. City or Tot		ber or Rui	al Route Number.
DIVISION (tal or Attending P irs after death. al Director: After t led in by the funars Certification:	4 Notificide	buildin	g, etc. (Specify)						Only or 10	m, State)		
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	30. Name and address of person w						מ נ	-1	11		2000	
	Alan S. Chanales 31. Dele filed (Month, Day, Year)		gistrar's Signatu		rove R	oac	1, KO	CKV1	lle, Ma	ryrand	2085	o U
State Registrar	SEP 25	2000	para s Signati	19.	Sport	1/2	,					

- Registrar



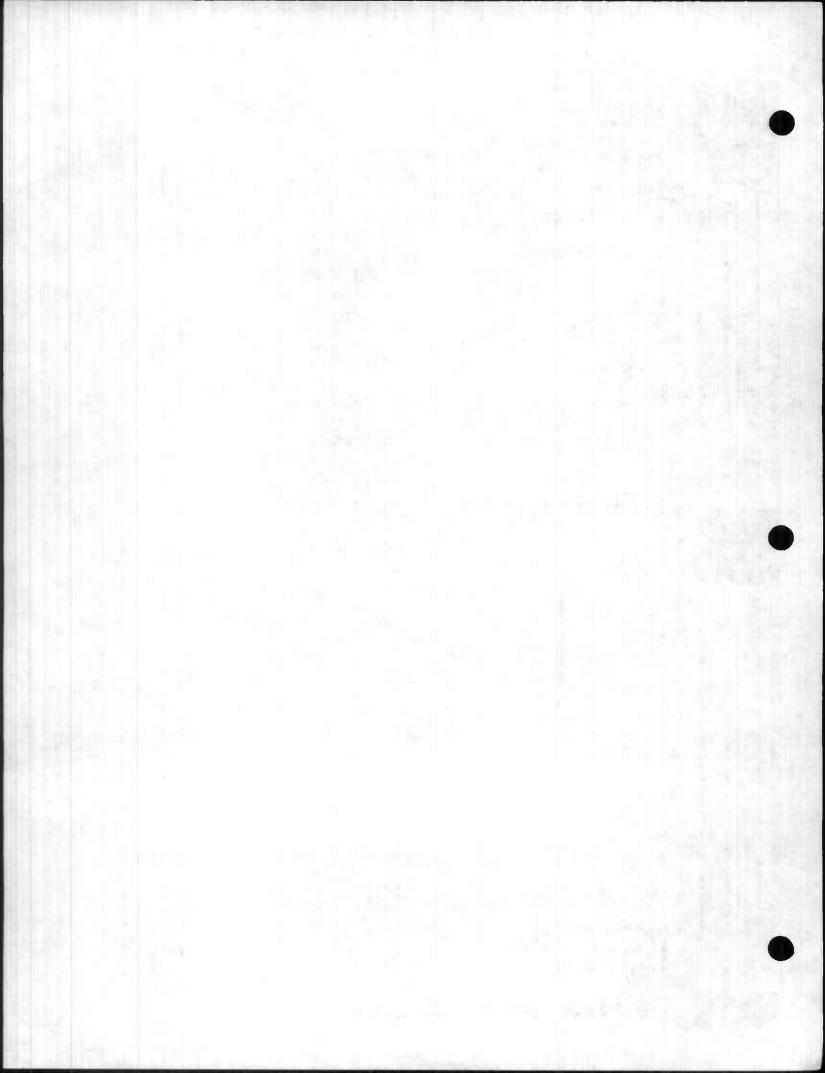
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 24^{Dey} **Physician** 2000 0800 DAVID DANIEL SCHNEIDER Sept /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Talbot Memorial Hospital Easton 8. Date of Birth (Month, Day, Year) DEC.19, 1918 If i Inder 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Yrs MD 216-03-7126 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at XX Yes 2□ No Director MD TALBOT EASTON 288-1 10g. Citizen of What Country? 10e Street and Number 10f. Zio Code or flerns 23a or USA 21601 303 PROSPECT AVE Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) David Schneider 1 XYes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☑ Married Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEHOLD REPAIR SERVIC OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental I Important: If Item 27 is marked oil any Injury or other 88 LOTTIE GOLDSTEIN BENJAMIN V. SCHNEIDER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 303 PROSPECT AVE EASTON, MD 21601 KATHERINE LOUISE SCHNEIDER/WIFE Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 9-25-2000 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility FELLOWS, HELFENBEIN& NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JOHN R. MERCEROR 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Ra V5 Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) 2915 Examin attending physician and for use as the burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence ot) eavs Oran Box 68760 Physician/Medical Due to (or as a consequence of) as t 23b. Did tobacco usa contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed this certificate has page 1 ☐ Yes -210 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: al or Attanding P safter death. i Director: After of in by the funer After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral Completely filled in the completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Dutchmans Lane 20 2160/ 503 David Oliver, M.D. SEP 2 5 2000 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Tellie Smith Trene September 18 2000 10:35AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Sacred Heart Hospital Cumberland H Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min Ct 2, 1915 5. Social Security Number 6 Sex 7. Aga (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** 1 My2 F 400H 84 Yrs. 216-01-8854 Director Usual Residence of Decedent the Manylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylei Department of Health and Mental Hygiene. Inmocrant: If them 27 is marked other than "natural", or ferms 23a or 28a-f show many injury or other traumatic event, traumatic to sent, traumatic and the propriet and injury or other traumatic event, traumatic and the propriet and the pr 1 Yasye No Directo Hampshire Augusta 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 26704 USA 71 Box 1495 Funeral Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes x No Specify: Specify white P X Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Retired Seamstress Berkowitz Factory 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumema) Be Robert Plummer Hazel (Streets) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. tnformant's Name/Reletionship (Type, Print) HC 71 Box 1495; Augusta WV 26704 Marvin R Sponaugle Sr. Soa: Method of Disposition 20b. Place of Disposition (Nema of 20c. Location - City or Town, Stata Date cemetery, cremetory or other place) X□ Buriel 2 □ Cramation 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Restlawn Memorial Gard9/21/ LaVale, MD 21. Signature of Funeral Service Licensee Scarpeidis Fulleral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one-cause on each line. Approximete Interval Between Onset and Death **Physician** Infaction Immediate Cause (Finel disease or condition resulting in death) /Medical Mys Coudi-1 Acua Examiner Due to (or as a consequence of): Examiner Cardis my opathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of): and P.O. Box 68760, physiclan Physician/Medical the Due to (or as a consequence of) 98 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contributs to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, P 24b. Were eutopsy findings available prior to 24e. Was en eutopsy performed? Completed completion of cause of death? page 2 has 20 No 1 Yes 1 Yas 2 No certificate Division of Vital To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifice 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Numbar, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. edicai 29e. Certifier (Check only one) 29c. Licensa number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) D40693 September / 2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Samir Elian -921 Seton Drive, Suite F, Cumberland, mo 21502 31. Date file 8 10 10 2ay 1 7 2000 32 Registrar's Signature State Registrar

in the same of

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Dete of Deeth Month 1. Decedeni's Neme (First, Middle, Last) 3. Time of Death **Physician** Sep 24, 2000 Smith 04:00pm Elwood Earl /Medical 4c. County of Deeth 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland Nursing Home Cumberland If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 F Yrs Feb 16, Director 78 1922 214-14-7728 Usual Residence of Deceden the Meryland 10a. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hama 23a or 28a-f ahow the Medical Examiner must be nothed at ¥ Yes 2 No Director Allegany Cumberland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21502 USA 110 Mullen Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. hours after 1 □X'es 2 □ No WW II If Yes, Give Year or Dates: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: white by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) illed within 72 h Hygiene. other than "netu 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit. Department of Heelth and Mental Physient important: if tem 27 is marked other that any injury or other traumatic event, that page. Chessie System 12 Laborer 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be (Smith) Lula Boyd U. Smith 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ada R. Smith 110 Mullen Street; Cumberland, MD21502 Woh. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dete cemetery, cremetory or other place) 9/27/ 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donelion 5 ☐ Other (Specify) Rocky Gap Veterans Cem 2000 Flintstone, MD Scarpelli Funeral Home P.A. 21. Signatury Funerel Service Licensee Cumberland, Maryland 23a. Pert1, Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart leiture. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediale Cause (Finel cerebrovascular accident 3 weeks disease or condition resulting in death) Examine Due to (or es e consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or es a consequence of): Box 68760. that the death certificate be edical Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? Records. P.O. signed by t d be detach 1 ☐ Yee 2 ☐ No 3 🕱 Probably 4 ☐ Unknown carcinoma of colon ð 24b. Were autopsy lindings aveilable prior to 24a. Wes en autopsy been a Should Completed chronic obstructive pulmonary disease completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital 25. Was case referred to medicel examiner? Be 26. Place of Deeth (Check only one) To the Hospital or Attanding Physics within 24 hours after death.
To the Funeral Director: After this ce completely illied in by the funeral dire Hospitel: Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Deeth 28d. Describe how injury occurred Certification: 5 Pending investigation 1 K Netural 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 28e. Plece ol Injury - At home, larm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28I. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homleide edical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only

Mes

State Registrar

30. Name end address of person who completed ceuse of deeth (Item 23a) (Type, Print)

Sunil K. 625 Kent Avenue Cumberland MD 21502 Gupta M.D. 32 Registrar's Signeture

29b. Signeture end title of con-

29c. License number

D33280

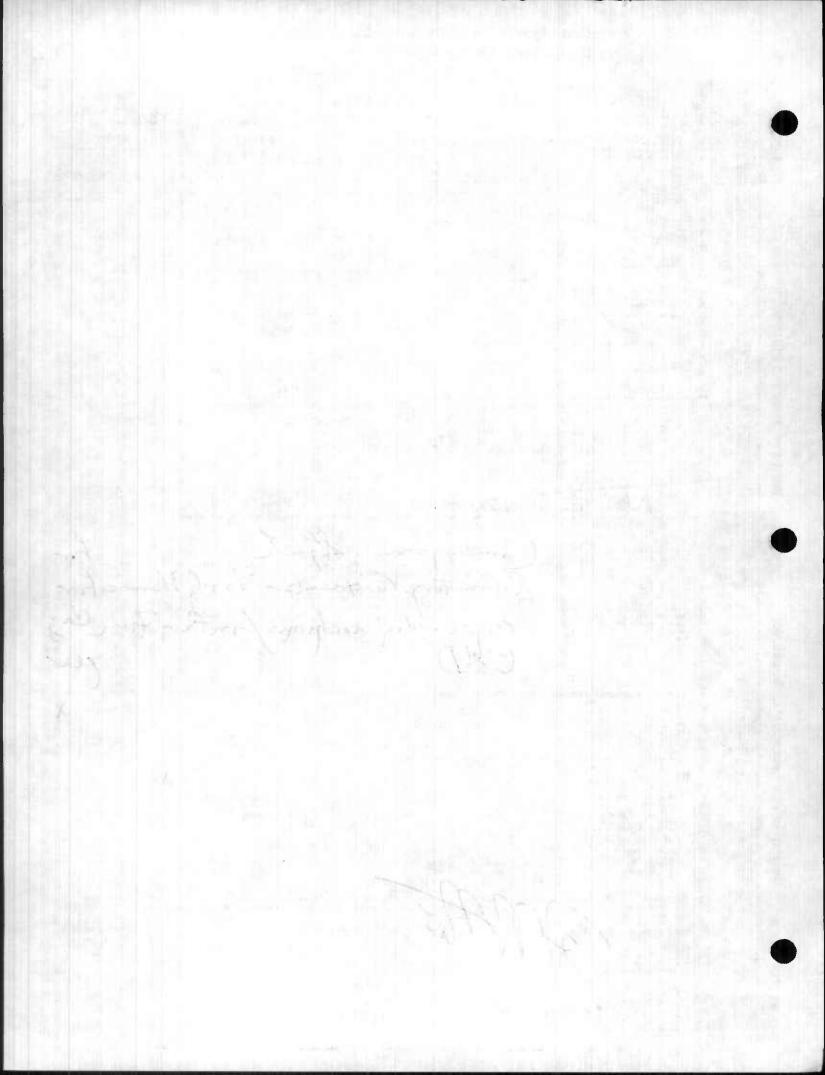
29d. Date signed (Month, Day, Year)

Sep 25, 2000

86651 5000 900--

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 0 6 2

s conflicate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit and a large and the completed by Physician/Medical Examiner. To Be Completed by Physician/Medical Examiner. To Be Completed by Physician/Medical Examiner.	NELSC 4a Facility Nema PENINSUI 5. Social Security 220-16-7 Usuel Residence 10a. Stete Florida 10e. Street and No. 1362 Br. 11. Marital Status 1 Never Mer 3 Widowed (Spe. Elementery/Sec. 12 17. Fethar's Neme Nelson 19a. Informent's News	If not institution, giv LA REGIONA Number 6. S 7328 1 10b. County Sarasot umber cenner Par ried 2 Married 4 Divorced 15. Decedent's Excity only highest gray ondary (0-12) o (First, Middle, Last,	HUDSON ra street and number) AL MEDICAL Sex 7. Agr 1 M 2 F 7. Agr 12. Wes Decedent Armed Forcas? 1 M Yes 2 M Yes 2 M Yes College (1-4or 5 2 m) 13. Agreement of the complete of the complete of the college (1-4or 5 2 m) 14. Agreement of the college (1-4or 5 2 m) 15. Agreement of the college (1-4or 5 2 m) 16. Agreement of the college (1-4or 5 2 m) 17. Agreement of the college (1-4or 5 2 m)	CENTER e (In yrs. last birth 75 10c. City, Town Venic Evar in U.S. No WW II	or Location e 10f. Zi 13. Wes Decriff Yes, spending Yes Decedant's Use	SAL er 1 Yaar If Undar 2 Deys Hours ip Code 34292 edent of Hispanic Origeoify Cuben, Maxican 2 No Specify: uel Occupation ork done during most use retired)	Min. (Month, March) March min? (Specify Yes or Puerto Rican, etc.)	Dey Ac. County WIC Birth Dey, Year) 21,1925 10g. Citizen of W USA No- 14. Race Blace Specify	of Deeth OMI CO 9. Birthplece (State or Country) Maryland 10d. Inside Cit 1 Yas Whet Country? See - American Indien, ck, White, etc.			
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s been signed by the attending physician and 2 should be detached for use es the burial-transit are in injury or other transmission of the physician/Medical Examiner To	Nelson 19a. Informent's N	Neme/Reletionship (r's Neme (First, Midd	da, Maiden Sumem	1a)			
s been signed by the attending physician and 2 should be detached for use as the buriel-transit and in an an ance. The pleted by Physician/Medical Examiner	19a. Informent's N	Neme/Reletionship (Ru	th Tucker					
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to be a signed by the attending physician and a should be detached for use as the burial-transit an incident pleted by Physician/Medical Examiner	20e. Method of Disposition 20b. Place of Disposition (Neme of cematery, crametory or other place) 20c. Loc cematery, crametory or other place)											
to be a signed by the attending physician and a should be detached for use as the burial-transit an incident pleted by Physician/Medical Examiner	1 🖾 Burial 2			cematery	, crametory or	eme of other place) ns Cemetery	Date 9/19/00		City or Town, State			
to be a signed by the attending physician and a should be detached for use as the burial-transit an incident pleted by Physician/Medical Examiner	-	uneral Service Licer		Coldib		and Addrass of Fecilit		ALLING	CO11/ VII			
to be a signed by the attending physician and a should be detached for use as the burial-transit an incident pleted by Physician/Medical Examiner	21. Signal de Of	A A A	40		Hollow	Jay Funera	1 Home Pro	ofessiona	1 Associat:			
to be a signed by the attending physician and a should be detached for use as the burial-transit an incident pleted by Physician/Medical Examiner	PN	enid A.	Common	M01051	501 Sr	now Hill R	d., Salish	bury, MD	21804			
to be a signed by the attending physician and a should be detached for use as the burial-transit an incident pleted by Physician/Medical Examiner	23a. Perti. Enter	the disease, or com	nplications that caused one cause on each lin	the deeth. Do n	ot enter the mo	ode of dying, such es	cardiac or raspireton	y errest,	Approximete Intervel Bets			
to be a signed by the attending physician and a should be detached for use as the burial-transit an incident pleted by Physician/Medical Examiner	SHOCK, OF HE	art landre. List Only	One Cause on eech iii	10.		00	1		Onset and I			
is been signed by the attending physician and 2 should be detached for use as the burial-transit pleted by Physician/Medical Examiner	tmmediete Ceuse	(Finel	(and	hose	ne	Store	6		7			
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is been signed by the attending 2 should be detached for use especially be pletted by Physician/Me	that initiated evan	r injury	2	Due to (or as a co	onsequence of	cac. Link	111	1 = 0 -1				
ts been signed by the attendir 2 should be detached for use pleted by PhysicianA	resulting in death	Last	PU	17)	etrement Miss and	-	/		200			
2 should be d	5		0	10					TRAV			
2 should be d	ā											
2 should be d	Part II. Other sign	ificant conditions of	contributing to death be	ut not resulting in	tha underlying	cause given in Pert I.	23b. D	ild tobacco use co	entribute to the cause of			
2 should							1	☐ Yes 2☐ No	3 □ Probably 4			
5 M G	3						24a. W	/es en eutopsy erformed?	24b. Were autopsy f aveileble prior t			
page 2	7							SHORING P	completion of c			
e ge o							XXXIII	- k				
77 -							1	☐ Yes 2 No	1 ☐ Yes 2 ☐			
certificate rector, pag							of Deeth (Check on	ly one)				
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atio tall	25. Wes case reference? 1 Yes 2	No ath	I A Inpatie	ry 28b. T			N					
Directo Directo 3 in by 1 ertific	25. Wes case reference? 1 Yes 2	No	28a. Dete of Inju (Month, Da	ry Year) 28b. T	M	1 Yes 2	NO					
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n 24 hou he Fune pletsity fi edical	25. Wes case reference exeminer? 1 Yes 2 2 27. Menner of Det 1 Neturel 2 Accident 3 Suicide 4 Homicide	No 5 Pending invastigetio 6 Could not be determined	28a. Place of Injudicing, etc.	ury - At home, fer	m, street, fecto	1 Yes 2 Dry, office	28f. Locatio City or	Town, State)				
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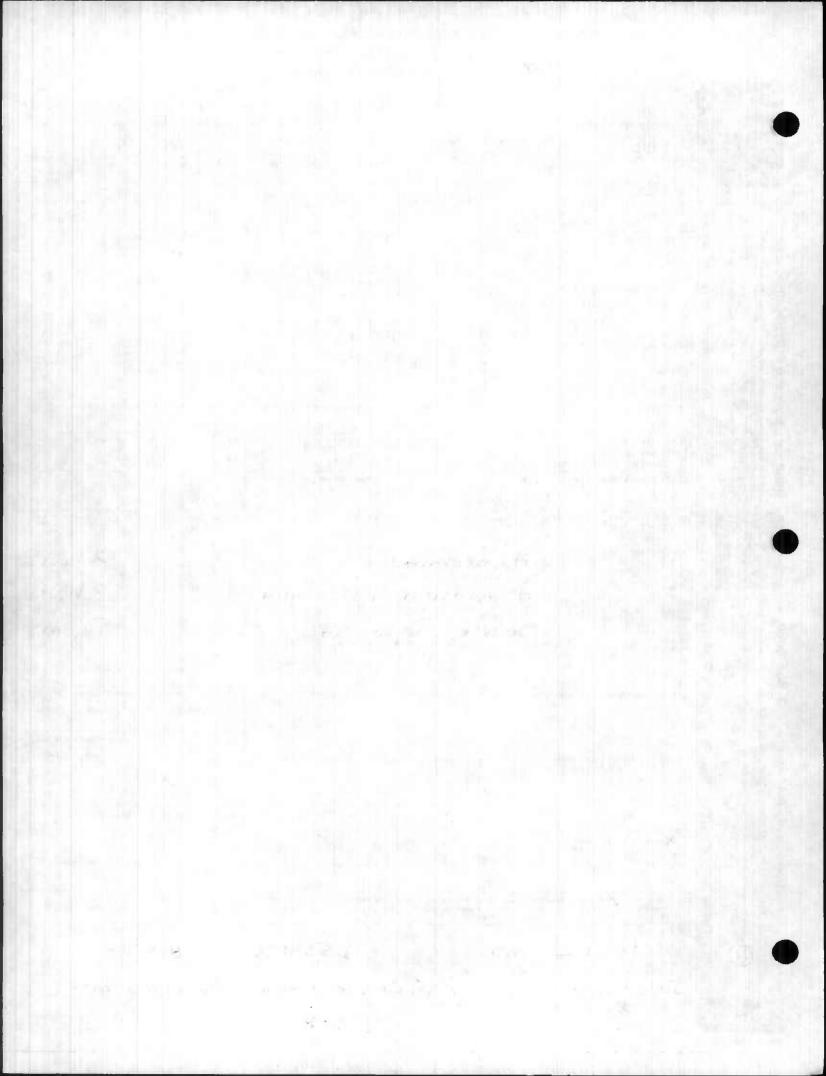


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State of Maryland / Department of Health and Mental Hygiene 00 32063 Certificate of Death

	And the same			00	rincate of	Doam		Heg. No.		
	Physician /Medical	Decedent's Name (First, Middle, La	John Will:	iam	Stark Sr		2. Date of De Month	+ 24 á	Year 2000	3. Time of Death 7. 50pm
	Examiner	4e Facility Name (If not institution, git Franklin Squar	ve street and number) e Hospita	1 Cen	ter	4b. City, Town, or L Rosedal			of Death	e
_	Funeral Director	5. Social Security Number 6.		rs. last birthday, Yrs.			8. Date of Bir (Month, De Mar 7	rth ey, <i>Year)</i> 1916	9. Birthpl Count Mt	lace (State or Foreign try) Zion,Md
aryland	show dat	Usual Residence of Decedent 10a. State 10b. County Ma Balti		City, Town or Le					10	0d. Inside City Limits 1 ☐ Yes 2X No
with the Mary	t or 28s-f sho be notified at Director	Md Dalti	more B	altimor	10f. Zip Code			10g. Citizen of	Whet Coun	
6	0 8 0	1047 Lerew Way			21205			USA		
20 s after death	or Heme 23a aminer must y Funeral	11. Merital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	U,S. 13.	Was Decedent of If Yes, specify Cult	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)		ca - America ck, White, e	etc.
00-	al Exa	3 Widowed 4 Divorced	Year or Dates:	16a Door	dent's Heuri Occu	postion				
Maryland 21215-0020	ygiene, ver than "natural, it, the Medical Completed	15. Decedent's E (Specify only highest gr Elementery/Secondery (0-12)	College (1-4or 5+)			pation a during most of work ed) Hospital	king	Hospi		ustry
D D		17. Father's Name (First, Middle, Las	0)	DOM	Decours	18. Mother's Nam	ne (First, Middle			
lan of	kad ott fit ever fit ever	Charles W. Star	k			Emma	Sharple	ess		
ary C	M bos man	19e. Informant's Name/Reletionship	(Type, Print)	19b. Mail	ng Address (Stree	et and Number or Ru	ral Route Numb	er, City or Town,	State, Zip	Code)
		Bessie J. Stark		1047	Lerew	Way Balt	timore,	Md 2120)5	
altimore, Maryland	unt: If there are other	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Cont	Removal from State	cemetery, cre	osition (Name of matory or other place) Cemeter	,	Date 1g 27 20	20c. Locetion	- City or Too nton I	
Balt U	Departr Imports any Inja Bride	21. Signature of Funeral Service Lice	Rudach	D		Burdock Fi			1.500	Section 1
Die	avoleion.	23e. Part1. Enter the disease, or conspock, or heert feilure. List only	inflications that caused the de yone cause on each line.	eath. Do not en	10 Churc ter the mode of dy	h St Kit ring, such as cardiac	or respiratory	r, Md	21538	Approximate Intervat Between Onset and Death
- 1 /I	nysician Medical xaminer	Immediate Cause (Final disease or condition resulting in deeth)	· Hypoxe	(or as a conse	evenes elle					2 hours
77	ne.		A = 07 CA	Fan	0	Ainoma				2 hours
acute	trans	Sequentially list conditions,	Due to	(or es e conse		2111011116	min min		t	11001-
60, be ax	clan abunal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	. Severe	De	menti.	A			C	JUEBRS
OX 68760, certificate be executed	nding physician and use as the burial-transit	that initiated events resulting in death) Last	Due to	(or as a conse	quence of):		0.00			7
	for u						1			
P.O.	ed by the attedest for detached for	Part II. Other significant conditions	contributing to death but not r	resulting in the u	inderlying cause g	iven in Part I.		Yes 2 No	3 Prob	o the cause of death?
Division of Vital Records, P.O.	within 24 hours after death. Jo the Funeral Director: After this certificate has been signed by the attercompletaly filled in by tha funeral director, page 2 should be detached for Completaly filled in by tha funeral director, page 2 should be detached for Medical Certification: To Be Completed by Physicia						24a. Wes	s en eutopsy ormed?	ava	ere autopsy findings ailable prior to mpletion of cause death?
The Is	pege Com	DEALOR TO DE					10	Yes 2 No	10	Yes 2 No
ita in:	s certificate he director, pege	25. Was case referred to medical examiner?				26. Place of Dea	ith (Check only	one)		
of V	this ce al dire	1 ☐ Yes 2 No		ER/Outpatie	III JUDA			idence 6 □Ott	. , ,	1)
O LIG	After the funeration:	27. Manner of Death 123 Natural 5 ☐ Pending	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	W		28d. Describe	how injury occur	red	
Division of Attend	thin 24 hours after death. The Funeral Director: After the timpletaly filled in by the funeral Medical Certification:	2 Accident Investigation 3 Suicide 6 Could not Investigation 4 Homicide determined	00 - 51 41-1 4	t home, farm, st]Yes 2 □ No	28f. Location City or To	(Street and Num own, Stete)	ber or Rure	I Route Number,
- Hospita	within 24 hours after d To the Funeral Direct completally filled in by Medical Certifi	29a. Certifier (Check only one) 29a. Certifying P	hysicien: To the best of my k miner: On the basis of exami and manner stated.	(nowledge, deet ination and/or in	h occurred at the vestigation, in my	time, date end plece opinion, death occu	, end due to the rred at the time	cause(s) and m , date and place,	anner es st and due to	ated. the cause(s)
oth	Me Within	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date signe		
	(1)	D53462						8 25	5/00	
10	(6)	30. Name and eddress of person who	completed cause of death (II	tem 23a) (Type	Print)					
		Jude Munes	es mo 7	1845	DAKWO	od ROA	d Be	alto. W	S Q	1061
	State	31. Dete filed (Month Pay, Year)	32. Registrar's Sig		1					

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32064 Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 26, 2000 Aug. 8:15 AM Myrtle Ina Spencer 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Maust Home Care Center Accident If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Dete of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) Months Deys Hours Min 1□M 2□F Yrs. 220-52-9417 Usuel Residence of Decedent 96 15,1904 West Virginia Mar. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Garrett Oakland 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21550 IISA Turner Douglas Road 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th Housewife Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Thedoshia Belle. Beverlin Ellsworth ---- Lemasters 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 122 Highland Drive, Oakland, Md. 21550 Carl M. Spencer/Son 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Garrett Co. Mem. Gardens 8/29/00 Oakland, Md. 21550 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Enry California 22. Name end Address of Fecility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset end Death Immediete Cause (Finel disease or condition resulting in deeth) atherosclerotic cardiovascular disease yrs Due to (or es e consequence of) Due to (or es e consequence of) Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown History of CVA

Physician /Medical **Examiner**

and

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det

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page 2 should

After this certificate hes

al or Attending Physician: The safer deeth.

In Director: After this certificate of in by the funeral director, pe

Mospital 24 hours a Funeral D

To the To the Comple

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The law requires that the deeth certificate be executed

Box 68760.

P.O.

of Vital Records,

Division

Examiner

Physician/Medical

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Medical Certification: To

Physician

/Medical

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Funeral

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Item 27 I

Department of H Important: If Ite any Injury or of once.

the Medical Examiner must be notified at

Director

Funeral

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Completed

with the Merylend

deeth Heme

Pages 1 and 2 should be filed within 72 hours after

Maryland 21215-0020

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

24a. Wes en eutopsy performed?

24b. Were autopsy findings evailable prior to completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death

5 Pending investigation

6 Could not be

28c. Injury et Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Hother Spesional care home 28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stele)

29a Certifier

31. Dete filed (Month, Pay, Year)

2 Accident

3 Suicide

4 Homicide

Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end manner es stated.

| Certifying Phyelclan: To the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s)

29b. Signature

29c. License number D30035

26. Piece of Deeth (Check only one)

29d. Date signed (Month, Dev. Year) 08-28-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

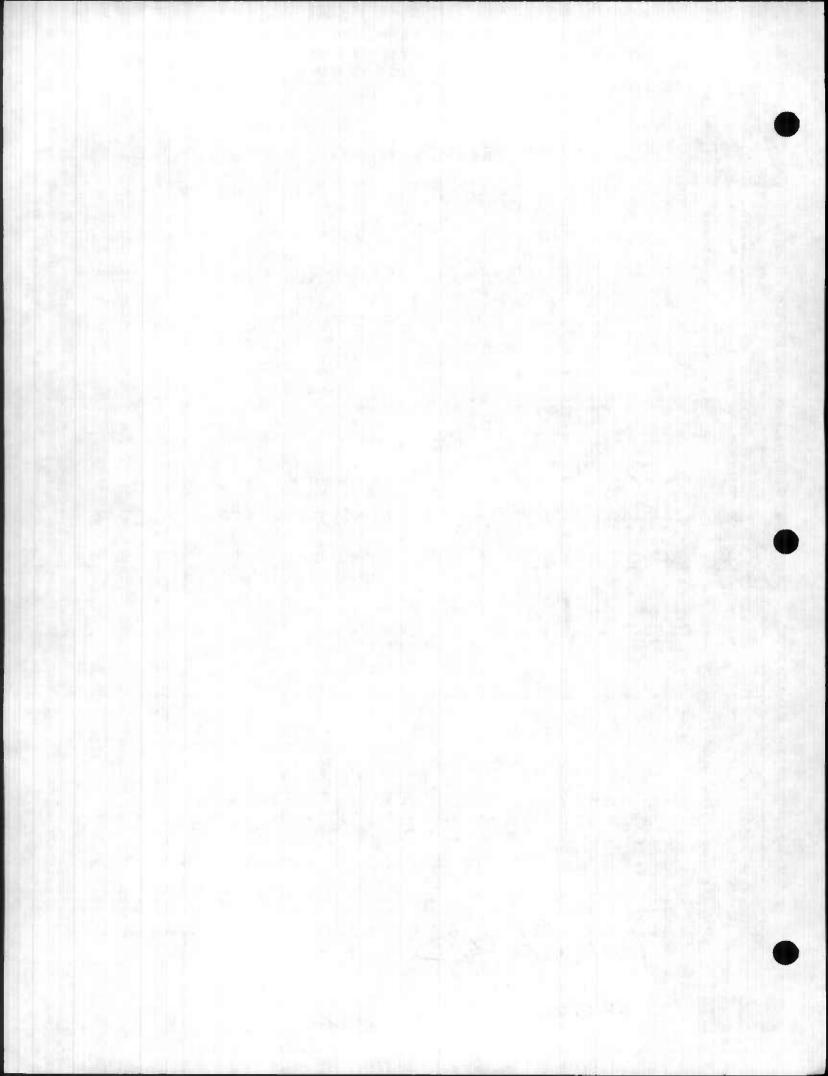
Donald R. Richter, M.D. 1533 Memorial Drive Oakland, MD 21550

State Registra

32. Registrer's Signeture

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)



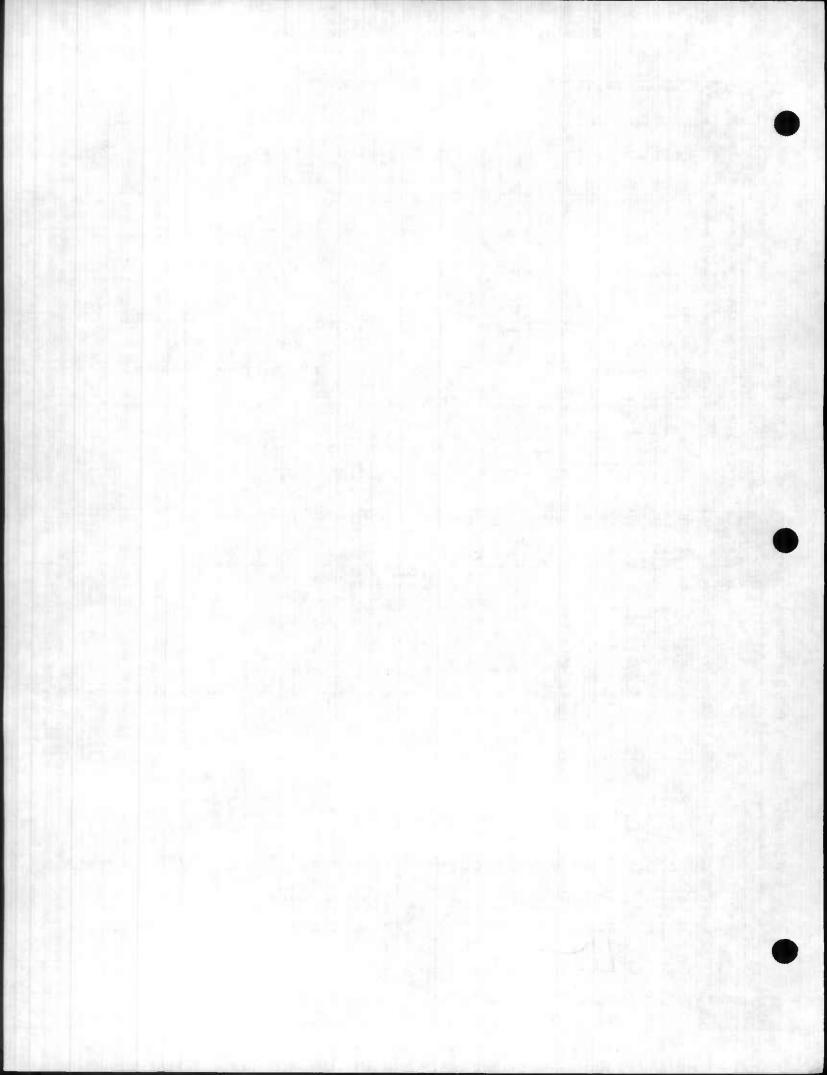


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State of Maryland / Department of Health and Mental Hygiene

32065

				Ce	rtificate of	Death	100	Reg. No.		
		1. Decedent's Nama (First, Middla, Last)					2. Data of De Month	ath Day	Yaar	3. Tima of Death
47	Physician /Medical	David Lansdal	e SWEITZ	ZER				er 10,		8:45 AM
À.	Examiner	4a Facility Neme (If not institution, give s	treet and number)			4b. City, Town, or				
193		Garrett County Me	morial Hospi	tal		0akland		G	arret	t la
	Funeral	5. Social Security Number 6. Sex	M 2DE	s. last birthday	Months Deys	If Under 24 Hrs Hours Min.	(Month, Da	th y, Year)	9. Birthpla Country	ca (Stata or Foreign
	Director	214-16-2545	78	Yrs.			Mar. 17	7, 1922	Mary	
1	1.	Usual Rasidance of Decedant 10e. Stata 10b. County	10c. C	City, Town or L	ocation				100	d. Inside City Limits
- American	adat o	MD Garr	ett		Oakland					1 ☐ Yas 2 X No
1	or 28s-1 s be notified Director	10e. Street and Number			10f. Zip Coda			10g. Citizan of V	Vhat Countr	y?
1		3508 Broadford Roa	1			21550			SA	
1	iner mat		2. Was Decedant Evar in	U,S. 13.	Wes Decedant of F If Yas, specify Cubi		pecify Yas or No		e - Amarica	
0	Fur Par	1 ☐ Nevar Married 2 ☑ Married	Armed Forcas? 1 ☑ Yes 2 ☐ No If Yas, Giva				to Rican, atc.)		k, Whita, et	c.
020	by B	3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva Yaer or Datas: WW	II	1□ Yas 2∏ No	Specify:		Specify		White
0-9	ted for	15. Decedant's Educ	ation	16a. Dec	edant's Usual Occup	pation	rkina	16b. Kind of Bu	sinass/Indu	istry
21	ygene. we then neture. t. the Medical.	(Specify only highest grade Elementery/Secondary (0-12)	Collega (1-4or 5+)	lifa.	kind of work dona DO NOT use retire	d)	King			
2	Con the	7		0	wner			Grain P		sing
Pu	Be went	17. Fathar's Nema (First, Middla, Last)					ma (First, Middla,			
yla	To To	Edward Theodor	e Sweitz			Anna	Florer		Sweit	
Maryland 21215-0020	de la	19a. Informant's Name/Ralationship (Typ			ing Addrass (Street					
. 1	Tage of the same o	M. Louise Sweitzer			Broadfor	d Road,	Oakland,	Maryla:		
10	5 = 5	20a. Mathod of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re		cemetery, cri	amatory or othar pla	1				
altimore	diny diny	4 Donation 5 Othar (Specify)			rk Cemete		9/13/00	Deer Pa	rk, M	aryland
Bal	any in	21. Signature of Fugaral Service		2	2. Nama and Addra Stewart F		ome			
		OZUMUL M. YULL	DO.		32 S. Sec	ond St.	Oakland	1, MD 2	1550	
Cor a	-	23a. Part1. Entar tha diseasa, or complic shock, or heert failure. List only one	ations that causad tha da cause on aech line.	ath. Do not er	nter the moda of dyle	ng, such as cardia	c or raspiretory a	rrast,		Approximata Intarval Batween Onsat and Death
	hysician /Medical	Immediata Causa (Final		40.7						oriout and Douti
	xaminer	diseasa or condition rasulting in daath)	coronary						ye	ears
	وَ السلام		high bloc	or as a conse					ye	ears
a la	ing physician and e as the burial-transit Medical Examiner	Sequantially list conditions.	Dua to	(or as a conse	equanca of):					
0,	ian a unial-	Sequantially list conditions, if any, laeding to immadiata cause. Enter Undartying Cause (Disease or injury							1	
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0	ed by the detached	Part II. Other significant conditions cont	ributing to death but not re	asulting In tha	undarlying causa git	van in Part I.				the cause of death?
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	rs after death. al Director: After to led in by the funeral Certification:		ounding, oto. (Spot	y ,			Tierra L			
Hoen d	within 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical		cian: To the best of my keer: On the basis of axaminand mannar stated.							
£ 5	Toth	29b. Signatura and title of certifier			29c. Licans	se number		29d. Data signe	d (Month, D	Day, Year)
) The			D153	333		9/11/	2000	
	MILLON	30. Name and address of person who cor	npleted cause of daath (It	am 23a) (Type	, Print)	Mark.	P. 1			10 4 5 1
		Dr. Thomas Johnson	, MD 311 1	. Four	th St., C	akland,	Maryland	21550		
	State	31. Data filed (Month, Day, Year)	32. Registrar's Sig	- 4		1				
	Registrar	SEP 1 2 20	00 Janes	P	. Apoul	La la				



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State of Maryland / Department of Health and Mental Hygiene 00 3 2 0 6 6

					Cel	nificat	e or i	Death		Reg. No.			
Physician /Medical		PAUL	н.	TRAUTWI	EIN				2. Date of I Month SEPI	Day 27, 2	Year 2000	3. Time of Death 5:00 P	
Examiner	4a Facility Name	(If not institution, gi	ve street and nui	mber)			4	lb. City, Town, or I	ocation of De	ath 4c. County	of Death		
	822	BRICE RI	D.					ROCKVI	LLE	MC	NTGO	ŒRY	
uneral	5. Sociel Security			7. Age (In yrs. la	st birthday)	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of I	Birth Day, Year)	9. Birthp	place (State or For	
irector	123-16-0	0652	1 X M 2□ F	74	Yrs.	MOTITIS	Days	HOUIS WIII.	FEB.	2, 1926		WYORK	
-	Usual Residence												
B 18	10a. State	10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Li	
Tor for	MD.	MONTGO	MERY		R	OCKVI	LLE					1 X Yes 2 □	
or 28a-f a be notified	10e. Street and Nu					10f. Zip				10g. Citizen of	What Cour	ntry?	
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iner matt	822	2 BRICE						852			U.S.A		
un der	11. Marital Stetus		Armed Fo		13.	was Deced	ent of H	ispanic Origin? (S an, Mexican, Puert	o Rican, etc.)		ce - Americ ck, White,		
0 E		ried 2 Married	1 Yes, Giv	2 □ No ⁄e		1□ Yes	No No	Specify:		Specif	v:		
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un de	Elementary/Sec		College (1	1-4or 5+)	life.	DO NOT us	e retired	1)					
5 H 6			5+		SY	STEMS	ANA	LYST		F.D.	.A.		
Be C	17. Father's Neme	(First, Middle, Las	t)					18. Mother's Nen	ne (First, Midd	ile, Maiden Sumai	ne)		
D O	1	PAUL	K. T	RAUTWEIN	ī				ENTHERL	HAM	ILTON		
Page 1		Name/Relationship		10101111111111111111111111111111111111		nn Address	(Street	and Number or Ru	iral Route Number, City or Town, Sta				
train.													
Other tr	WILL 20a, Method of Dis	TRAUTWEI	MOGVM	20h Di-	351			BALTI	Date Date	20c. Location		num State	
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Nury or	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHAMBERS CREMATORY								9/29/0	O RIVE	RDALE	, MD.	
5-4	21. Signature of Funeral Service Licensee 22. Neme and Address of Facility												
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se as the bu	that initiated events resulting in death) Last Due to (or as a consequence of):												
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certificate he rector, page				100 C				ha ilitar		Yes 27 No	1	☐ Yes 2☐ No	
director,	25. Was case refe examiner?	erred to medical	Manakal				100	26. Place of Dea	ath (Check on	ly one)			
5 G		₹ No	Hospital: 1	Inpatient 2 E	R/Outpatier			4 U Nursing F	lome 5 R	esidenca 6 Ot	her (Speci	fy)	
nere nere	27. Manner of Dea		28a. Date (Mon	of Injury th, Day Year)	28b. Time o	1 2	8c. Injui Wor	y et k?	28d. Descrit	e how injury occu	rred		
e fu	1 ☑ Natural 2 ☐ Accident	5 Pending investigetion			,ury	M		Yes 2 □ No					
To the Funeral Director: After completely filled in by the funer Medical Certification:	3 Suicide	6 Could not I	4 286. PIECE	of Injury - At hor	ne, farm, str	reet, factory	, office		28f. Location	n (Street and Num	ber or Run	al Route Number,	
al Director: After to the In by the funeral Certification:	4 Homicide	4.0	buildi	ng, etc. (Specify)	,				City or	Town, State)			
To the Funeral completely filled Medical Co	29a. Certifier	130 Cartifidae D	hyeiden: To the	hast of my know	dedre dest	h occurred	at the ti-	ne dete and place	end due to t	he cause(s) and m	anner es e	stated	
To the Funeral Director: After the completely filled in by the funeral Medical Certification:	(Check only	2 Medical Exa	miner: On the bi	asis of examinetic	on end/or in	vestigation	, in my c	ne, dete and plece pinion, death occu	rred at the tim	ne, date and plece	, and due t	o the ceuse(s)	
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000	29b. Signature and title of conflier 29d. Date signe								ed (Month,	Day, Year)			
1+1	Muy Spy. 28, 200.							2000					
,,,	30. Name and add	iress of person who	completed caus	e of death (Item	23a) (Type.	Print)			DI HIT I		-		
		RAYMON	W BA	755	3941	I FF	RRAH	EA DR	WHE	ATUN 1	10	20906	
Ctoto	31. Date filed (Me)	Oth Day, Year		egistrar's Signatu	ure A						-		
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Registrar -	0	- 1 A 4 5	0000	Cherry	D.	100	Pelly						

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 1. Decedent's Nama (First, Middla, Last) Month Sept. 29, 2000 5:10 AM Shirley S. Townsend 4a Facility Nama (tf not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Montgomery Gaithersburg Wilson Health Care Center | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Min. | March 9, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (tn yrs. last birthday) 1□M 2区F Yrs. 88 1912 493-12-6859 Michigan Usual Rasidanca of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYas 2 No Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? # 219 United States 401 Russell Avenue, 12. Was Decadant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. 11. Maritel Stetus 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify. 3 ⊠ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 12 Housewife Home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Sumama)

Hazel

19b. Mailing Addrass (Street and Number or Rurat Routa Number, City or Town, Stata, Zip Code)

4804 Jamestown Road, Bethesda, Maryland 20816

22. Nama and Addrass of Facility DeVol Funeral Home

Data

10 East Deer Park Dr., Gaithersburg, MD. 20877

Thurston

20c. Location - City or Town, Stata

29d. Data signed (Month, Day, Year)

September 29, 2000

19/29/00 Alexandria, Virginia

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Directo

Funeral

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Completed

Be 2

Carmi

19a. Informant's Name/Ralationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21 Signatura of Funeral Sarvica Licans

29b. Signeture end title of certifie

31. Date filed (Month,

Robert Birschbach,

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

32. Ragistrer's Signetura

20a. Mathod of Disposition

Penelope T. Jones/Daughter

1 ☐ Burial 2 ☑ Cremetion 3 ☐ Ramoval from Stata

Sharp

Funeral

Director

item 27 is marked other than "natural", or flema 23e or 28e-1 show other treumstic event, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after deeth N Department of Health and Mentel Hygiene. Important; if Item 27 is marked other than "naturat", or Itema 23 ent is injury or other treumatic event, the Medical Exercises must page.

Baltimore, Maryland 21215-0020

Examiner Physician/Medical Be Completed by Medical Certification: To

To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detected for use as the bunk-trensit Division of Vitai Records, P.O. Box 68760,

23a. Part1. Entar tha disease, or comp shock, or haart failura. List only	olications that caused tha daat ona causa on aech line.	h. Do not entar tha m	ode of dying, such as card	ac or raspiratory errest,	Approximete Intarval Between Onset and Death
Immediata Causa (Final diseasa or condition	· Respe	extor	y facl	use	2 days
rasulting in death)	Carone Due to to	or as a consequence of	there	Luie	/
Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (o	r as a consequence o	or you	isiase	
·	d				
Part II. Other significant conditions of	intributing to death but not real			23b. Did tobacco use co 1 ☑ Yes 2 ☐ No	ntribute to the cause of death? 3 Probably 4 Unknow
Pulmona	yhypere	tension	c	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Cacherye	la 10			1□Yes 2DRNo	1 Yes 2 No
25. Was casa rafarred to medical			26. Place of D	eath (Check only one)	
examinar? 1 ☐ Yas 21公 No	Hospital: 1 ☐ Inpatiant 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Homa 5 ☐ Rasidenca 6 ☐ Oth	ar (Specify)
27. Mannar of Death 1 ⊠ Natural 5 ☐ Pending 2 ☐ Accidant invastigation	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	red
3 Suicide 6 Could not be determined	28e. Place of Injury - At h. building, etc. (Specif	28f. Location (Street and Numb City or Town, State)	lumber or Rural Routa Number,		
				ce, and dua to the cause(s) and ma curred at tha tima, data and place,	

29c. License number

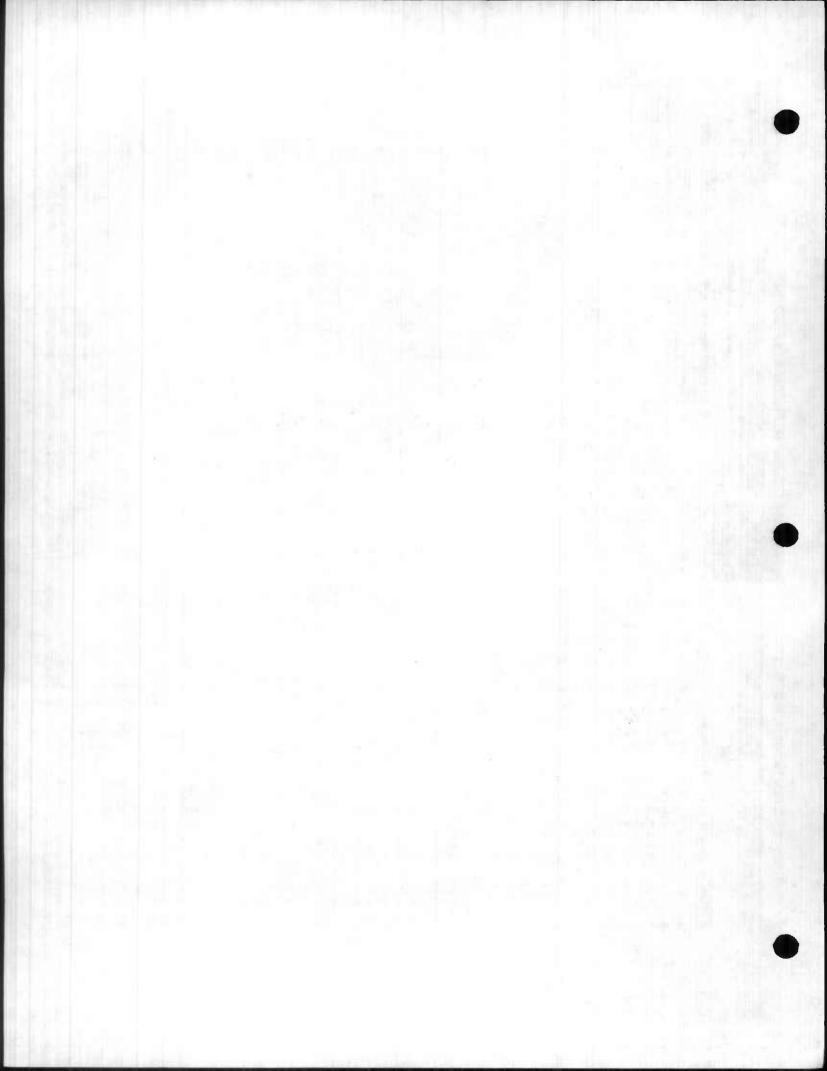
M.D., 6320 Democracy Blvd., Bethesda, Maryland 20817

20b. Placa of Disposition (Nama of cematery, crematory or other place)

Metropolitan Crematory

DHMH 16 Rev 6/95

State Registrar



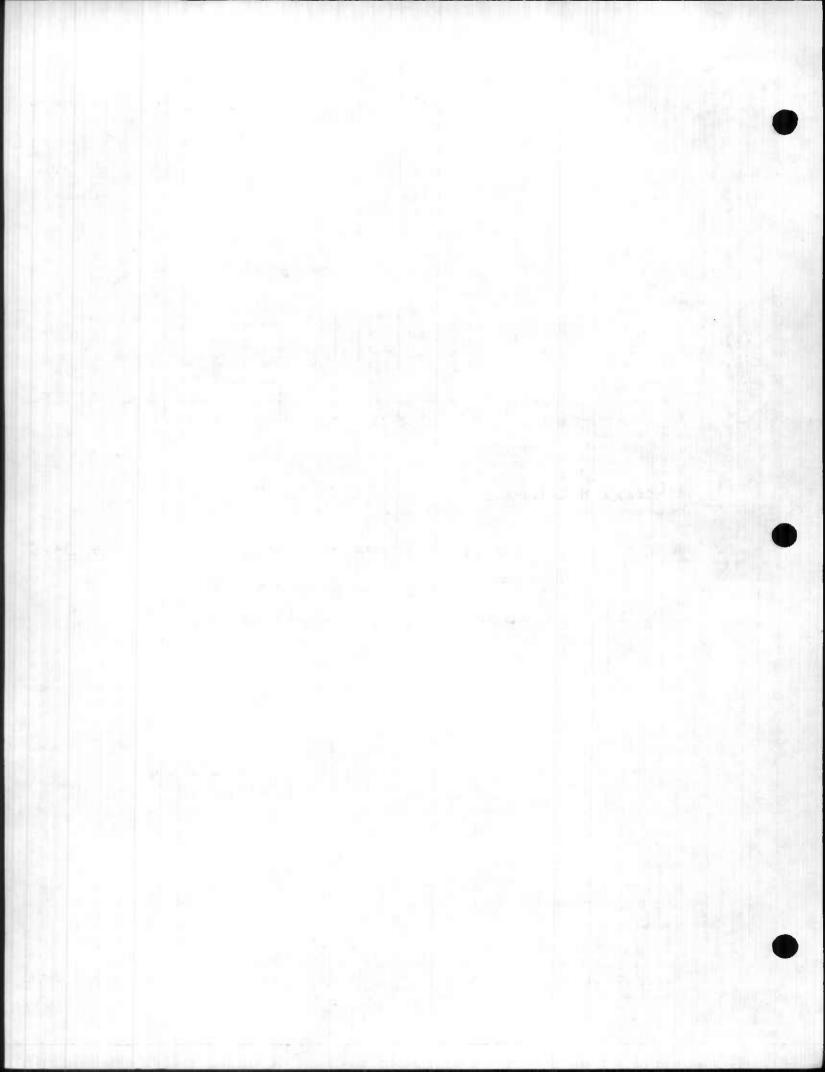
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Yeer September 23, 2000 Physician 3:50 PM Minnie Tillery /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Jan. 25, 1911 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 10 M 2 XF Devs Hours 89 Yrs. 068-22-9444 North Carolina Director Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ral, or items 23s or 28s-f shore Examiner must be notified at 1 X Yes 2 □ No Director Md Takoma Park Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7525 Carroll Avenue 20912 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. pernit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite any Injury or other traumatic event, or Medical Examina any Injury or other traumatic event, or Medical Examina once. 1 Never Merried 2 ☐ Merried African Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced American Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 8 Seamstress Garment District 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Berry Tillery Minnie Exum 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Angela Satterthwaite/ Niece 6728 2nd Street, N.W. Washington, D.C. 20012 20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Kremetion 3 ☐ Removel from Stete Chesapeake Crematory, Inc. 9/27/00 Beltsville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses 22. Name and Address of Fecility McGuire Funeral Service, Inc. Kelliberry banks 7400 Georgia Avenue, N.W. Wash., D.C. 20012 23a. Part 1. Enter the disease, or complications that a sed the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on (a) h line. Approximete tntervel Between Onset end Deeth **Physician** tmmediate Ceuse (Finet diseese or condition resulting in deeth) ANOXIC ENCEPHALOPATHY /Medical DAYS Examiner Due to (or es a consequenca of): Examiner ACUTE MYOCARDIAL INFARCTION physician and s the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): ARTERIOSCLEROTIC HEART DISEASE Box 68760 Physician/Medical Due to (or es e consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco uas contributs to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy 1 Yes 2 No 1 □ Yes 2 □ No Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 tnpatient 2 □ ER/Outpatient 3 □ DOA After this 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Pending investigation Injury death. 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: completaly filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as steted.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as steted.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as steted. 29e. Certifier To the 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number preph B. Mugerd, MA SEPT. 24, 2000 D0008425 5 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) JOSEPH B. MIZGERD, M.D. 7600 CARROLL AVE, TAKOMA PARK, MD 20912 31. Dete filed (Month, Dey, Year) 32, Registrer's Signature State SEP 28 2000 Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2 Date of Deeth Month 9 **Physician** 2 Day 2000 Rodney John Twigg 19:37 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Allegany Memorial Hospital & Medical Center Cumberland 8. Date of Birth (Months Days Hours Min. Feb 16, 1939 Birthplace (State or Foreign Country)

MD 5. Social Security Number 6 Sex **Funeral** ₩ 2DF 370-38-7498 Director Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 □ No Cumberland 28a-f Directo MD Allegany 10s. Street and Number 10f. Zlp Code 10g. Citizen of What Country? ŏ 12012B Bedford Road NE 21502 USA Harrie 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 223 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Americen Indian, Black, White, etc. al Hygiene. d other than "netural", or its event, the Medical Examins 1 Never Married 2 Married 1 ☐ Yes 2☐ No Specify. Specify: white by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 12 Cotlege (1-4or 5+) contruction worker Local 616 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Mental Calvin E. Twigg Viola C (Skelley) marked 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) important if Health, any Injury or other Lovie E. Twigg RODNEY 12012B Bedford Road NE; Cumberland MD 21502 Baltimore. 20s. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State Pages -1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 9/25/00 Cumberland, MD Scarpedrio Funeral Home, P.A. Cumberland, MD 21502 23a. Part1. Enter the disease, or contributations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) CARDIO-RESPIRATORY FAILURE Examiner Due to (or as a consequence of) Physician/Medical Examiner PROBABLE SEPSIS use as the burial-transit the centificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and hed for use as the burial-tran Box 68760. Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? B 2X No t TYes 3 Probably 4 ☐ Unknown RECTAL CARCINOMA, COPD, MALNUTRITION Division of Vital Records, à The law requires 24b. Were autopsy findings available prior to completion of cause of death? Completed 24s. Was an autopsy page 2 s 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other; 4□ Nursing Home S□ Residence 6 □ Other (Specify) Certification: To 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA 100 28d. Describe how injury occurred Injury at Work? Ahar 5 Pending investigat Natural 2 Accident 1 Yes 2 No after death Director: A o in by the i 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Bural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 C Homicide To the Hospital within 24 hours To the Funeral B Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBER 22, 2000 D30197 Mame and address of person who completed cause of death (Item 23a) (Type, Print) MEMORIAL HOSPITAL SUITE 402 DR.KENNETH ROCK CUMBERLAND, MD 21502 31. Date SE P 27. 5 2000 32. Registrar's Signat State parker Registrar

DHMH 16 Rev 6/95

370-38-7498

TWIGG

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State of Maryland / Department of Health and Mental Hygiene

32070

3. Time of Deeth

2:45 AM

10d. Inside City Limits

Onset end Death

3 YEARS

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Day, Year)

AUGUST 31, 2000

OAKLAND, MD 21550

WHITE

1 ☐ Yes 2 No

Physician	
/Medical	
Examiner	

Funeral Director me 23a or 28a-f show Herns ? ò

the Maryland with death the Medical Examiner efter natural, nd Mental Hygiene. traumatic evant. t. Peges 1 end 2 should be furnent of Health and Mental I tant: If Item 27 is marked or other 0

Baltimore, Maryland 21215-0020

Physician /Medical Examine

bunial-tran pue physician the guipi etter for ed by the e signed by page 2 should been sate has certific this After

be exec 68760 Box o Records. of Vital Division Attending death. or Attend effer death Director: filled in by the To the Hospital o within 24 hours eff To the Funeral DI **Tpletehy**

10a State MD Directo Aq Completed Examine Physician/Medical by Completed Be 0 27. Manner of Death Certification: 1 Naturel 2 Accident 3 ☐ Suicide

11. Marital Status CHARLES disease or condition resulting in death)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month AUGUST 31, CHARLOTTE ANN TRESSLER 2000 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth MARYLAND GARRETT OAKLAND 2209 HUTTON ROAD 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, FEB 2, 9. Birthplece (State or Foreign 7. Age (In vrs. last birthday) 1□M 2XF Deys Hours 49 Yrs. MARYLAND 216-56-1808 Usual Residence of Deceden 10h County 10c. City, Town or Location GARRETT OAKLAND 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 2209 HUTTON ROAD 21550 IISA 14. Raca - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY OIL COMPANY 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) WINDSOR HASTINGS LOTTIE BLANCHE APPLE 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OAKLAND, MD 21550 PARKE W. TRESSLER - HUSBAND 2209 HUTTON ROAD 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 8/2/00 4 ☐ Donetion 5 ☐ Other (Specify) EAST NEW MARKET CEM. EAST NEW MARKET, MD 21. Signeture of Fun val Service Licensee 22. Name end Address of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 10 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final VULVAR Due to (or es a consequence of): Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): thet initieted events resulting in death) Last Due to (or es a consequence of): Pert II. Other significent conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24a. Was en eutopsy 1 ☐ Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred

10

Registrar

Medical

KARL E. SCHWALM, M.D.

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

5 Pending investigation

6 Could not be determined

32. Registrer's Signeture Bigger



1 ☐ Yes 2 ☐ No

1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and pleca, end due to the ceuse(s) end manner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated.

29c. License number D 27205

Injury

28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

AUG 3 1 2000

4 \(\text{Homicide} \)

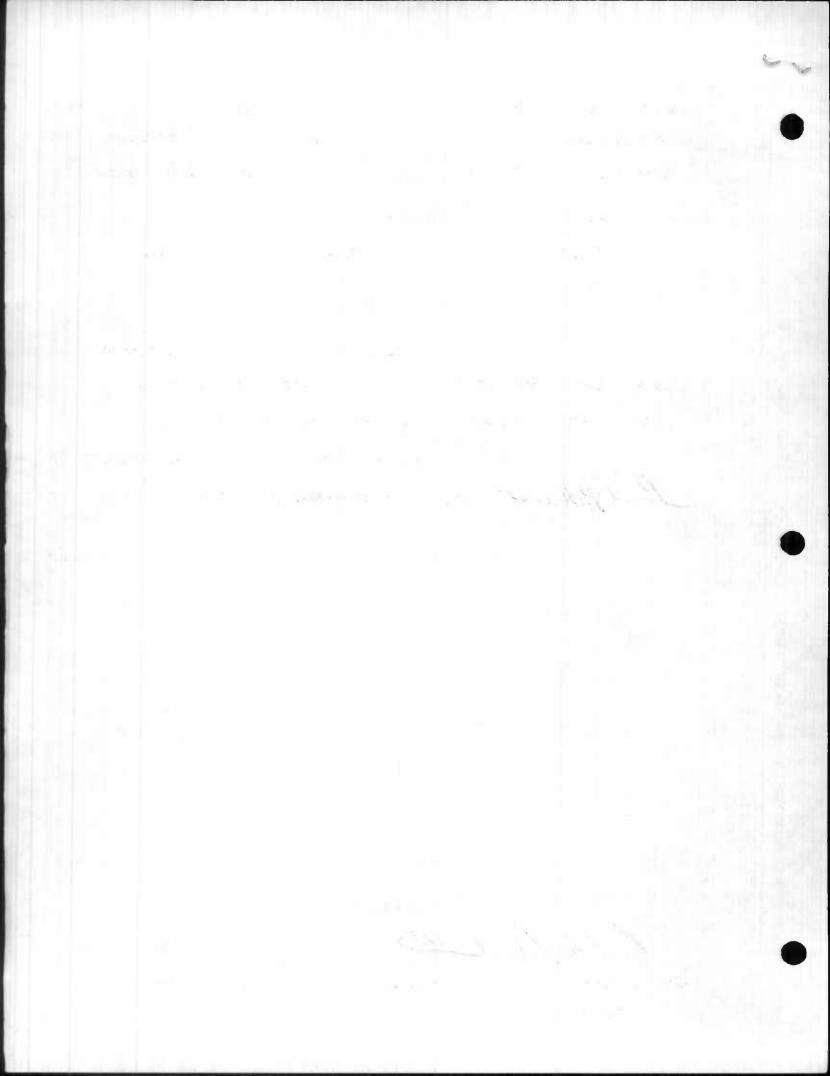
(Check only one)

29b. Signature and the of cegitles

31. Dete filed (Month, Day, Year)

29a. Certifier

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Dete of Death

00	3207
-	

3. Time of Death

	Physician /Medical	Elizabet	th Shotwe	ll Vale	0						Month Septer	mber 22	Year 200	9:	45 PM
	Examiner	4a Facility Neme (4550 No.	of institution, giver the Park						b. City, Tow Chevy				y of Death gome		
	Funeral Director	5. Social Security N 578-50-0	0456	Sex I□M 2☐ F	7. Age (In yrs.	last birthday) 62 Yrs.	If Under Months	1 Year Deys	If Under 24 Hours	4 Hrs. 8 Min.	Month, De Feb 1	8, 1938	9. Birth Cou NC	place (Sta intry)	te or Foreign
	Du *	Usual Residence o	10b. County		10c. Gi	ty, Town or Lo	cation				****			10d Insid	e City Limits
	r 28a-f ehow	MD	Montgon	acru		evy Ch									Yes 2 No
	vith the Ma			rery	CI	levy Cli	-	0.4.		-		40- 02	140-4-0-		
	S 0 N O	10e. Street and Nu	th Park A		201		10f. Zip					10g. Citizen of United			
	eath va 234									0.40				ican Indiai	
020	5 2 3 J	11. Marital Status 1 Never Marr 3 Widowed	ried 2 Married	Armed Fo 1 Yes If Yes, Giv	2 🗂 No '8	L FC	f Yes, spec	v	ispenic Origi n, Mexican, Specify:	nr (Spec Puerto Ri	can, etc.)	Bla	ick, White		,
Maryland 21215-0020	ed within 72 hours ygiene. er than "naturai", ft, tre Wedical Exi Completed by	(Spec	15. Decedent's Edify only highest grace ondery (0-12)		-4or 5+)		dent's Usua kind of wo DO NOT us ittee		ation during most o f f	of working	vorking US Sen			usiness/Industry ate	
rland	12 should be filed w h and Mental Hygien i e marked other the traumatic event, the		(First, Middle, Last, Sheppard									Maiden Suma			- 14
. Man	and 2 should saith and Men 127 ie marke er traumatic	The second secon	ame/Reletionship (Valeo /H			4550	Nort	h Pa	rk Ave			chevy			
Baltimore.	Pages 1 and 2 nent of Health ant: if item 27 i ury or other tra		position Cremation 3 5 Other (Specil		Siele	Place of Dispo cometery, crem hesapea					ep 26	20c. Location Beltsv			0
Balt	permit. Page Department of important: if any Injury or pace.	21. Signeture of Fu	uneral Service Licer	100 t	1	22			ss of Facility eral & Avenu	Cre e S	matior ilver	Service Spring,	es MD		
•	Physician /Medical Examiner	23a. Pert1. Enter t shock, or hee Immediate Cause disease or condition resulting in deeth)	the dispase, or com in fallyre. List only (Final on	Smal	l Bowe	l Obsti	ucti	on	g, such as c	ardiac or	respiratory e	errest,		Approx Interval Onset e	mate Between and Deeth
o.	icate be executed physician and s the burial-transit	Sequentially list co if eny, leeding to in cause. Enter Under	enditions, nmediate erlying	b	Due to (or as a consec	quence of):								
Box 68760.	Seath certificate be attending physicial of for use as the burnicial iclan/Medical	Sequentially list conditions, if eny, leeding to immediate cause. Enter Undertying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):													
O. Bo)		That it. Other significant conditions continuously to death out not resulting in the underlying cause given in half it.										to the ca	use of death		
٥.	requires that the de been signed by the should be detached										10	Yaa 2☐No			4 Unknow
Division of Vital Records.	The law requires rate has been sign page 2 should be Completed by									_	24a. Was perf	s an autopsy ormed?	(Vere autor vailable p completion of deeth?	psy findings rior to of cause
E	The la										10	Yes 2 No	1	Yes	2 No
ita/	ystclen: The is certificate director, pag	25. Was case refer	rred to medical								(Check only				
7	Physician: this cartific ral director, TO Be	1 ☐ Yes 2 ☐			npatient 2							idence 6 □O		ify)	
sion c	tal or Attending Ph is after death. of Director: After the ed in by the funeral Certification: 7	27. Manner of Deer	5 Pending investigation	n	of Injury th, Day Year)	28b. Time o Injury	М		yet k? Yes 2 □ N			how injury occu			
Divis	ospital or Attended thous after deat unerel Director. Sty filled in by the cal Certifica	3 Suicide 4 Homicide	6 Could not b	28e. Plece buildin	of Injury - At h	ome, farm, str	eet, factor	y, office		21		(Street and Num own, State)	nber or Ru	ral Route	Number,
	the Hospital of hin 24 hours a the Funerel Emplotely filled	29a. Certifier (Check only one)	1 KCertifying Ph 2 Medical Exar	niner: On the ba			vestigation	, in my o	pinion, death			, date and place	, and due	to the cau	
	0 5 0 E Z	29b. Signature and	title of pertiller				29	c. Licens	e number			29d/Date sign	ed (Month	Bay, Ye	ar)

		1 Yes 2 No 1 Yes 2 No										
25. Was case referred to medical	26. Plece of Deeth (Check only one)											
examiner? 1 Yes 2 No	Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home	ospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
27. Manner of Deeth 1 □ Neturel 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury et Work?	28d. Describe how injury occurred										
3 Suicide 6 Could not b determined	28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or Rural Route Number, City or Town, State)										
	ysician: To the best of my knowledge, death occurred at the time, date and place, end											

29b. Signature and title of pertiling

1. Decedent's Name (First, Middle, Last)

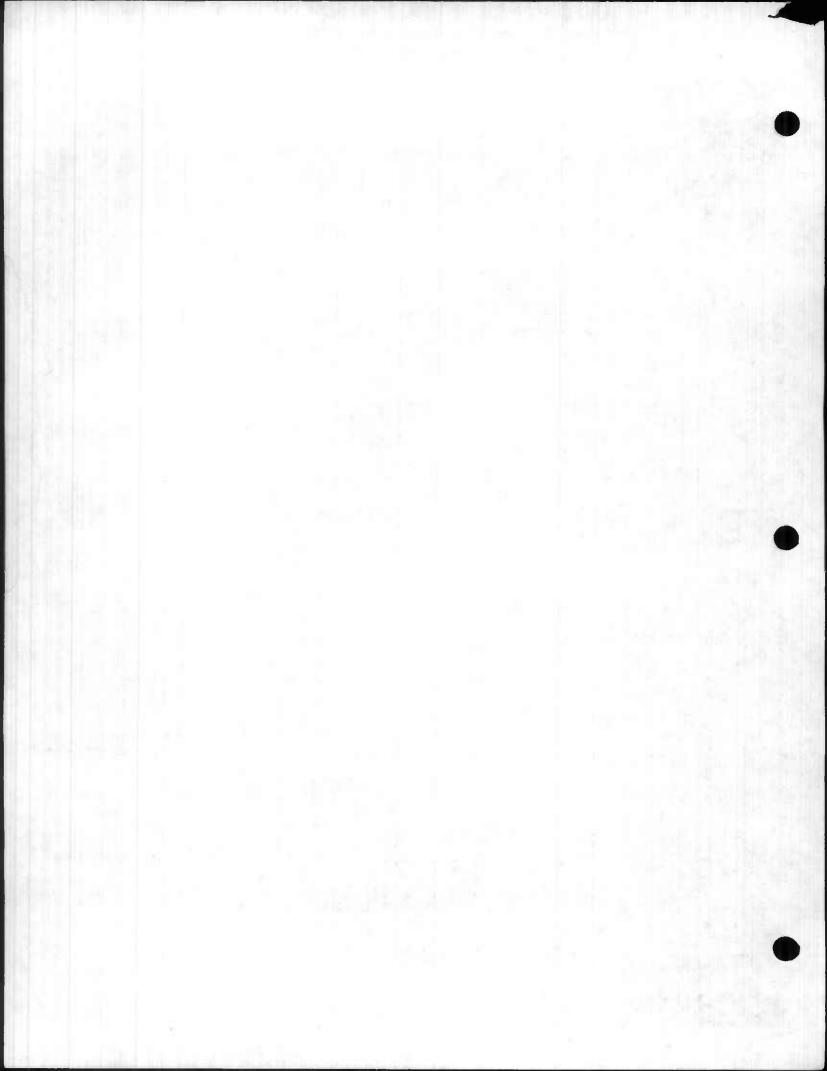
D29142

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Charles Boice M.D. 10301 Georgia Ave, Silver Spring, MD 20902

State Registrar

31. Date filed (Month, Day, Year) SEP 29 32. Registrar's Signature



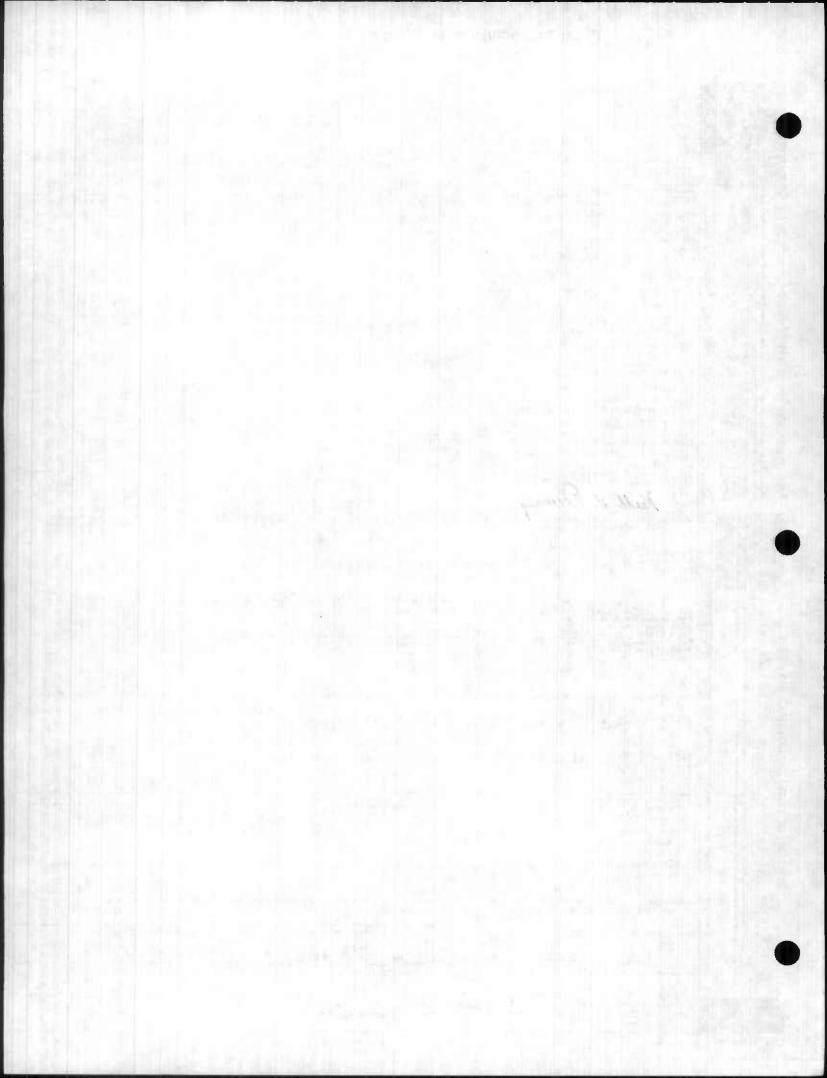
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		1. Decedent's Nama (First, Middla, Las	st)				2. Date of Dea			3. Tima of Death
	Physician /Medical	HAROLD	P	VANCE			Septemb	per 18,2	000	2:15 AM
P	Examiner	4e Facility Nema (If not institution, give 913 W. Schumaker		е		4b. City, Town, or L Salisbu			of Death	
ľ	Funeral Director	377-20-3010	ex 7. Aga (/ 23 M 2 □ F	n yrs. last birthday) 76 Yrs.	If Undar 1 Yaa Months Deys		8. Dete of Birt (Month, Day August			plece (Stata or Foraign stry) Cyland
	Maryland -f ahow fled at	Usual Rasidence of Decedent 10a. Stata 10b. County Maryland Wicomic		Oc. City, Town or Local Salisbur					1	0d. Insida City Limits 1 ☑ Yas 2 □ No
	death with the Maryland ma 23a or 28a-f ahow constitution models neral Director	10e. Street and Number 913 W. Schumaker	Manor Drive	e	10f. Zip Coda 218	304		10g. Citizen of V USA		try?
020	urs after	11. Marital Status 1 □ Nevar Married 2 ② Married 3 □ Widowed 4 □ Divorced	12. Was Dacedant Eve Armed Forces? 1 M Yas 2 □ No If Yas, Give Yaer or Datas: 19	10	as Decedant of Yas, specify Cu	Hispanic Origin? (Sp ben, Maxican, Puerto Specify:	pecify Yas or No- Ricen, atc.)		k, White,	
21215-0020	than the key	15. Decedant's Ed (Specify only highest gra Elemantary/Secondary (0-12)	Collega (1-4or 5+)	(Give ki		upation e during most of work ed) lanagement		16b. Kind of Bu		hone Co.
Maryland	De fil	17. Fathar's Nama (First, Middla, Last) James H. Vance				18. Mother's Nam Mary	e (First, Middle,	Maiden Sumam	_	
	it. Pages 1 and 2 sho frment of Health and rtant: If them 27 le ma njury or other trauma	19a. Informant's Name/Ralationship (1 Dorothy Mae Vance	**					Routa Number, City or Town, Stata, Zip Coda) r Dr., Salisbury, MD 21		
Saitimore,	80=8	20a. Mathod of Disposition 1	Ramoval from State	20b. Place of Disposi cematary, crama Parsons	atory or other pl	(ece)	Data 9/21/00	-		
Bait	permit. Departi Import any inj pace.	21. Signature of Funaral Service Licent	see			Funeral H Hill Rd.,				
	Pe swecuted from the purish fr	23a. Part1. Entar tha disaasa, or compshock, or haart failura. List only shock, or haart failura is only shock or	a. Respire		usuff ence or): Latina	iciery L Scler	osis	1001,		Approximata Interval Between Onset and Daath Lous 12 99
ox 68760	h certificate be a ending physiclen r use as the buria an/Medical E	Causa (Diseasa or injury that initiated avants rasulting in death) Last	c	a to (or as a conseque	ance of):					
P.O. B	that the daat ed by the att detached for	Part II. Other significant conditions or Pulmonary Hy		not rasulting in the unc			23b. Did		ntributa to	o the cause of death? bably 4 Unknown
ecords,	aw requires as been sign 2 should be	accident, Aor	tic sclerose	7				an autopsy rmed?	av	ere eutopsy findings allabta prior to impletion of causa death?
Œ	certificate has rector, page 2 Be Comp	25. Was casa raterred to medical		100		26. Placa of Dea	th /Check only o		10	☐Yas 2☐No
1	Z Sig	axaminar? 1 ☐ Yas 2 ☑ No	Hospital:	2 ER/Outpatient	3□ DOA C	ther: 4 Nursing H		dance 6 □Oth	ar (Specia	5)
Division of Vital	After fune	27. Mannar of Death 1 Anatural 5 Pending 2 Accidant invastigation 3 Suicida 6 Could not be				☐ Yas 2 ☐ No		now injury occur		
Divi	To the Mospital or Attending P within 24 hours after death. To the Funeral Director: Aftert completely filled in by the funeral Medical Certification:	4 Homicide detarmined	building, atc. (City or To	vn, Stata)		al Routa Number,
	the Hos in 24 hc the Fun pletely	(Check only 2 Medical Examone)	ysician: To the best of mainer: On the basis of ax and manner stated	amination and/or inva	astigation, in my	opinion, daath occu		data and plece,	and due t	o the ceuse(s)
		29b. Signature and titla of certifiar	1.			nsa number		29d. Date signe		
	5+17AC	30. Nama and addrass of person who	complated and a of deat	hau W	rint)	4883	, .	1-17.	40	sbury WD
1		HILDA IMEL 31. Data filed (Month, Day, Year)	10 HOU	LI HAN,	M.D	14055	Divis.	ion St.	Salis	spury MD
	State Registrar	SEP 2 0 2000	1	P. 1	sporks	/				

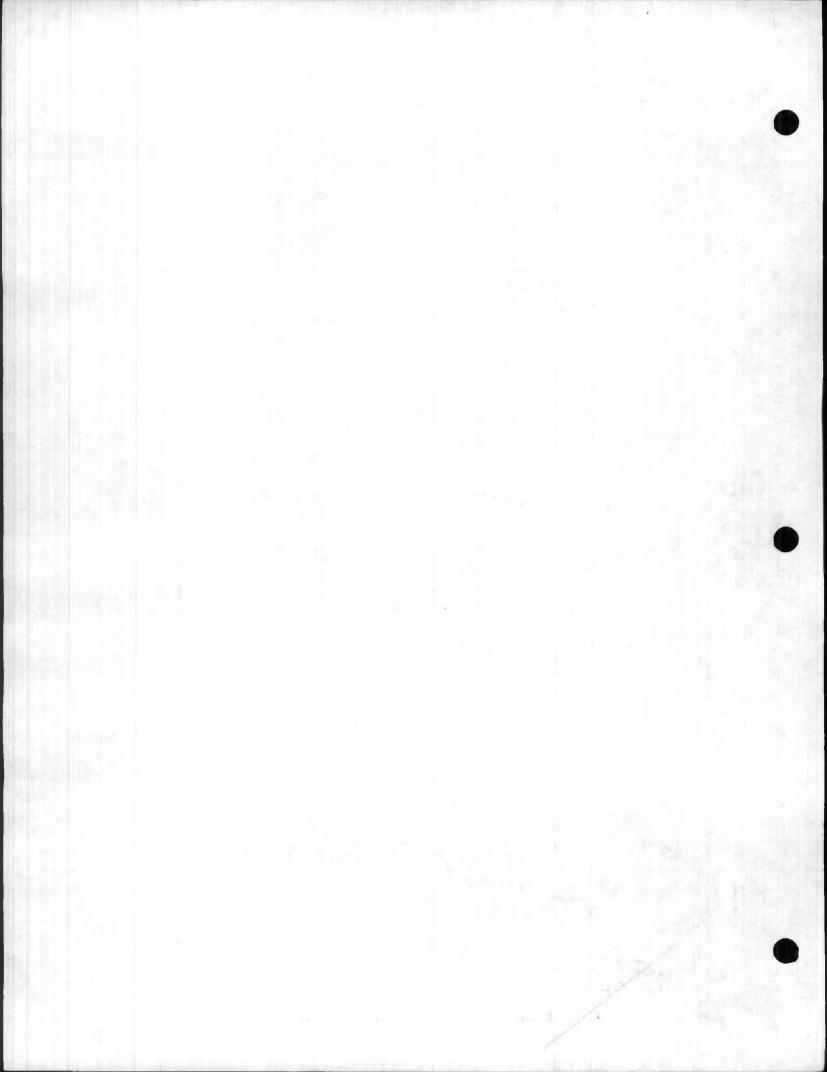
Registrar



State of Maryland / Department of Health and Mental Hygiene 00

TE RTS	5			State of Maryle		tificate of			eg. No.	U ,	320/3
	Physician		Decedent's Neme (First, Middle, La Pete		Virts			2. Dete of Dee Month SEDTEME		Year 2000	3. Time of Death 02:04 PM
	/Medical Examiner	-	e Facility Neme (If not institution, giv PRINCE GEORGES H	e street and number)			4b. City, Town, or L Cheverly		4c. County	of Deeth	ORGES
	Funeral Director	2	Sociel Security Number 219-03-8143		yrs. last birthdey) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth NOV • 3	1920	9. Birthpl Count Mary	ece (Stete or Foreign try) Land
	Meryland H show	1	Jsuel Residence of Decedent Oa. State 10b. County MD. Prince 0		City, Town or Lo Bowie	cation				10	od. Inside City Limits
	th with the Mer 23a or 28a-f s as be noutled		Oe. Street and Number 15908 Pennmano	or Lane		10f. Zip Code 20716	õ	1	0g. Citizen of N USA	Whet Count	ry?
020	within 72 hours effer deeth with the Menyland ene. than "natural", or itema 23e or 28e-f show he Medical Emerican must be incidited at home must be incidited at home for the medical place for the medical place for the medical place for the formal of the	2	Maritel Status Never Merried 2 Merried Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 24 Yes 2 □ No Will Yes, Give Year or Detes:	n U,S. 13. 1 TW2	Nas Decedent of I I Yes, specify Cub	Hispanic Origin? (Spen, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		ca - America ck, White, e y: Whi	etc.
21215-0020	filed within 72 hours Hygiene. ther than "natural", mt, in the decision	Dimpleted	15. Decedent's Ec (Specify only highest gra Elementery/Secondary (0-12) UNKNOWN	ducation ide completed) College (1-4or 5+)	16e. Deced (Give life. main	dent's Usuel Occup kind of work done DO NOT use retire CENANCE	pation during most of work d) engineer	king	16b. Kind of B		ustry
	d out Heart	1	7. Father's Neme (First, Middle, Last) James W.	Virts			18. Mother's Nem Pansy		Maiden Sumen aynard	ne)	
Maryland	2 sh land land reum		19e. Informent's Neme/Reletionship (Carole Alfie/ dau				tand Number or Rul nor Lane,			State, Zip	Code)
Baltimore,	Peges 1 and 2 nent of Health ant: If Item 27 I ury or other tra	2	198 Method of Disposition 198 uriel 2 Cremetion 3 4 Donetion 5 Other (Specific	Removal from Stete P	b. Pleca of Dispo cometery, crer OTOMAC	sition (Neme of netory or other ple Memorial	Gardens (Dete 09/07/00	20c. Location - Keyser	City or Ton	wm, Stete st Virginia
Balt	permit. Pe Depertmen Important: any Injury	-	21. Signeture of Funeral Service Licer	isee Bol	11	Name and Address Boal H	ess of Fecility Funeral Ho n St., We	ome esternpo	rt, Md.	215	562
68760,	Antificate be executed for a physician of physician and be set the burial-transit each for a physician and physici	calcal Evalline	Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, for, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b	o (or es e consec	luenca of):	Lnj	urit	25		
.O. Box	thet the deeth certified by the ettending detected for use a physical part.	yanciais	Pert II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause gi	ven in Pert I.		_/		the cause of death?
Records, P	e lew requires the hes been signed ge 2 should be demonstrated by	2						24a. Wes of perior	en eutopsy med?	24b. We eve cor	ere eutopsy tindings eilable prior to mpletion of cause death?
of Vital	Physician: The Corrector, per Correc	3 2	25. Wes case referred to medical exeminer? 1 🕅 Yes 2 🗆 No	Hospitel: 1 ☐ Inpatient 2	2 XER/Outpetier	nt 3 DOA Ot	26. Plece of Dee	th (Check only o		her (Specifi	ν)
ivision	or Attending ifter deeth. Nector: After in by the fune		27. Menner of Deeth 1	28a. Dete of Injury Month, Dey Year	28b. Time of Injury 12:15 At home, ferm, str	28c. Inju	iry et ork?] Yes 2 No	28d. Describe h Passen Impar	ow injury occur	med not her	or Vehicle Vehicle
	To the Hospital within 24 hours a vithin 24 hours a completely filled		29a. Certifier 1☐ Certifying Ph (Check only one) 1☐ Medical Exam	ysician: To the best of my niner: On the basis of exam end menner steted.	knowledge, deet ninetion and/or in	occurred et the tivestigation, in my	ime, date end plece opinion, death occur	, end due to the or rred et the time, o	euse(s) end m late end place,	enner es st end due to	eted. the cause(s)
D	To the within To the comple		29b. Signeture end title of certifier	ner, M.P) .	29c. Licen			29d. Date signe SEPTEMB		
	State Registrar	3	No. Neme and address of person who Sep who state filed (Month, Day, Year)	completed cause of deeth (PESTENCY 32. Registrers Si 6 2000	111 Pe		et, Baltin	more, Ma	ryland	21201	

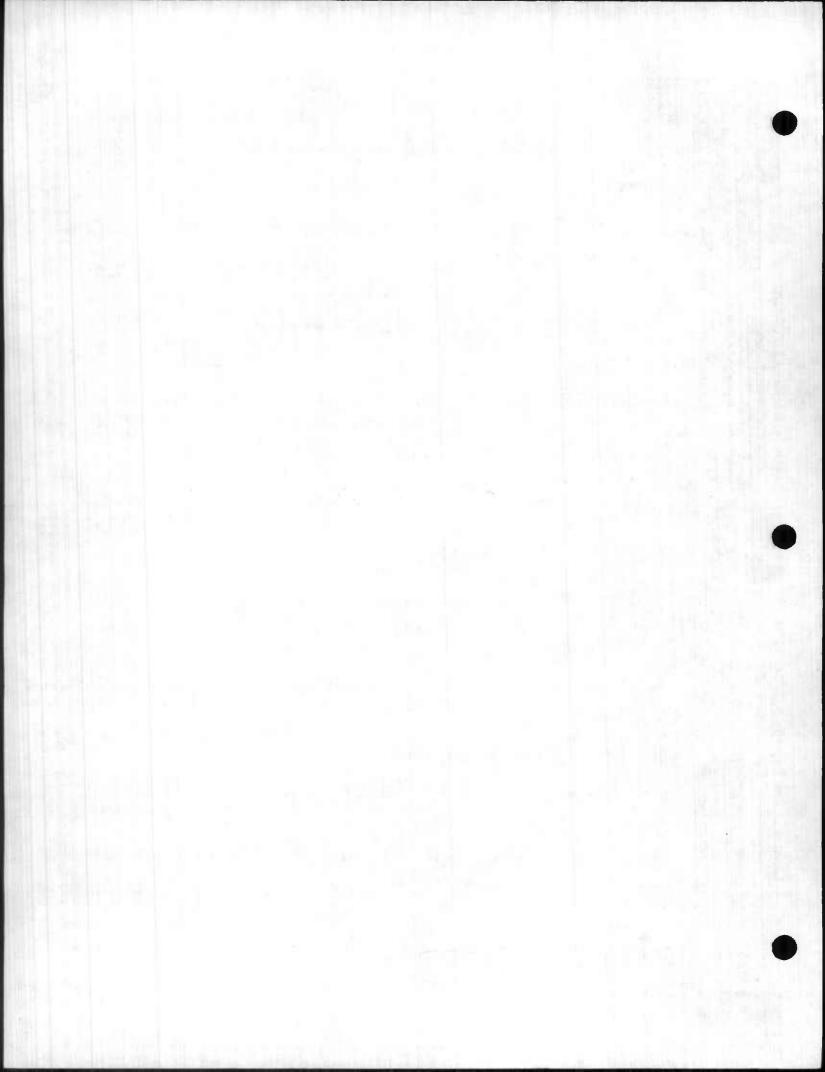
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month **Physician** Pauline Rosenfeld Wolfe Sep. 23, 2000 8:15 PM /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1801 E. Jefferson St., #408 Rockville Montgomery If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Deys 1□M 2월F Months 138-38-1263 92 Director New York Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Manya 1万 Yes 2 No Director MD 25a-f Montgomery Rockville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 Jefferson St., #408 1801 E. 20852 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give therms. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. the Medical Examiner 72 hours after 1 Never Merried 2 Married b 21215-0020 1 Yes 2 No Specify: Specify: White p Year or Detes: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 about be in ment of Health and Mental H ant: if them 27 is marked off lury or other traumatic even Be Isaac Rosenfeld Fannie Levinson 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karl M. Wolfe/ son 30 Dogwood Cir., Pinebrook, NJ 07058 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State Sep. 26 1 ☐ Buriel 2 ☐ Cremetion 3 ☑ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Elmwood Cemetery New Brunswick, NJ 2000 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, App. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Stroke Examiner Due to (or as e consequence of): Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical the Due to (or as a consequenca of): esn. signed by the at d be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? has page 2 certificate 1 Yes 2₺ No 1 TYes 2PTNo or Attending Physician: funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Neturel 5 Pending after death. 1 Yes 2 No Investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide 9 within 24 hours a To the Funerel D filled Hospital 29e. Certifier edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) end manner stated. one) 9 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0055258 3 26552 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 1801 East Jefferson Street Rockville, maryland Health B. Wilks MD Healt 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State 2000 2 8 SEP Registrar

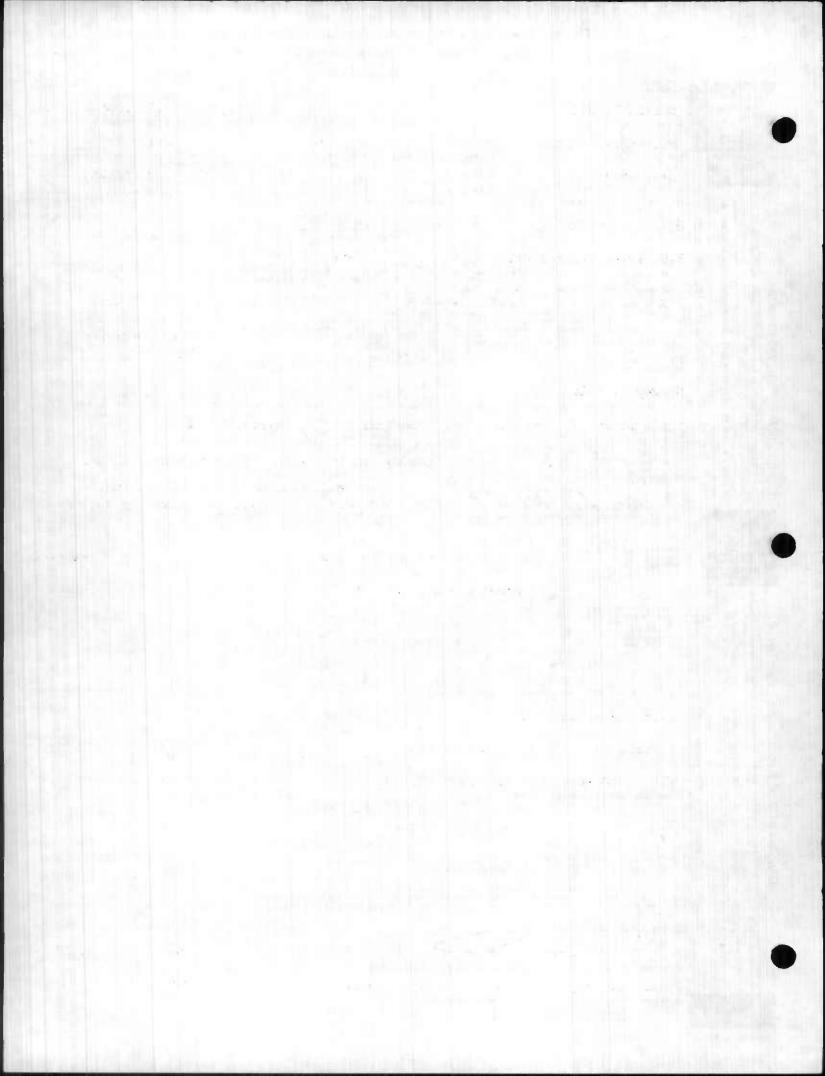
DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 2 0

		Decedent's Neme (First, Middle, Last	1)	Cen	ificate of	Death	2. Deta of Daat	eg. No.		3. Time of Death					
	Physician	Donald L. Wild	,				Month	Day	Yaar 2000	4:30 am					
	/Medical Examiner	4a Fecility Name (If not institution, give	street and number)			4b. City, Town, or I		4c. County of		4.30 am					
P.	Examiner	Montgomery General				01ney		Montgo	merv						
	Funeral Director	5. Social Security Number 6. Sa 231–18–6636		yrs. last birthday) 7 Yrs.	If Undar 1 Yaar Months Days		8. Date of Birth (Month, Day, Mar 10,	Year)		ece (State or Foreign ry) igan					
	show des	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	ation				10	d. Inside City Limits					
	or 28s-1 s	Maryland Montgomer	y S:	ilver Spi	1										
	Dire	10e. Street and Number	w=		10f. Zip Code		1	0g. Citizen of W	hat Count	ry?					
	eral	3701 International		in II C 13 W	20906	dienante Origin? (S	pacify Vas or No-	USA 14 Bace	- Amarica	n Indian					
020	172 hours efter death with the Meryland "natural", or frems 23a or 28a-f show sdical Exardinar must be notified at leted by Funeral Director	11. Marital Status 1 Naver Married 2 Married 3. Widowed 4 Divorced	12. Wes Dacedant Ever in Armed Forces? 1X Yes 2 □ No If Yes, Give Yaar or Detes:		Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puart Spacify:	Rican, atc.)		, White, e	tc.					
Ö	2 hou	15. Decedent's Edu	ucation	16a. Decede	ent's Usuel Occup	pation		16b. Kind of Bus	siness/Indo	ustry					
Baltimore, Maryland 21215-0020	filed within 72 ho Hygiene. ther than "natura int, the Wedleal.	(Specify only highast grad	College (1-4or 5+)	Teache	O NOT usa ratire	during most of world)	M	lontgome		-					
D	= I + E	17. Father's Name (First, Middla, Last)	<u> </u>	reacine		18. Mother's Nan	ne (First, Middle, M								
lan		Ernest A. Wild				Louise H	rench								
ary	₹ DE E	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailing	Address (Straa	and Number or Ru	ral Route Number	, City or Town,	State, Zip	Code)					
2	12 T	Linda W. Frew/ Da	ughter			le, Berli	n, MD 2	1811							
more	Pages 1 a not of the not of the of the not o	20a. Method of Disposition X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	demoval from State	b. Place of Dispos cemetery, cremi				20c. Location - C							
	injur a	21. Signature of Funeral Service Licensee 22. Name and Address of Facility													
Ba	Deg Awa	Funcia I Calling Emparal Home Inc													
	Physician	23a. Pav1. Enter the disease, or complications that causad the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Immediate Ceuse (Final disease or condition resulting in deeth) Due to (or es e consequence of):													
	/Medical Examiner														
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	40 CD 41	resulting in death) Last	Dua t	o (or as a consequ	ence of):										
ROX	daath certi e attanding ed for use a								1						
o.		Part II. Other significant conditions co	ntributing to death but not	rasulting in the un-	derlying cause gi	ven in Part I.				the cause of death?					
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Scord	been s should	Peripheral Arteri	ial Insuffic	iency			24a. Was a perform		eve	re autopsy findings ilable prior to npletion of cause leeth?					
=	icien: The law certificate has rector, page 2 Be Comp	Chronic Obstructi	ive Pulmonar	y Diseas	е	26 Place of Dec	1 ☐ Ye	es 20 No	1 🗆	Yes 2 No					
5		examiner?	Hospital:	2 ER/Outpatient	3□ DOA Ot	hor	ome 5 Reside		r (Specify)					
	tending Physical Correction: Te	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea		28c. Inju Wo		28d. Describe ho								
Division	tal or Attending P rs after death. al Director: After t led in by the funers Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, stre acify)	et, fectory, office		28f. Location (St City or Town	reet and Number, State)	er or Rural	Route Number,					
	To the Hospital or Atterview within 24 hours after der within 24 hours after der completely filled in by the Medical Certific		sician: To the best of my iner: On the basis of exam and manner stated.												
	Withir Comp	29b. Signature end title of certifier		Internis	29c. Licen	se number	2	9d. Date signed	(Month, L	Day, Year)					
	10	20 Name and address of source	-17	> '	D 3	35045		Septemb	oer 2	7, 2000					
		30. Neme end address of person who co	ompleted cause of death ((Reffi Zoa) (1ype, F	init]										
		Philip G. Henjum,	MD 3416 01	andwood		04 , 01n	ev MD	20832							

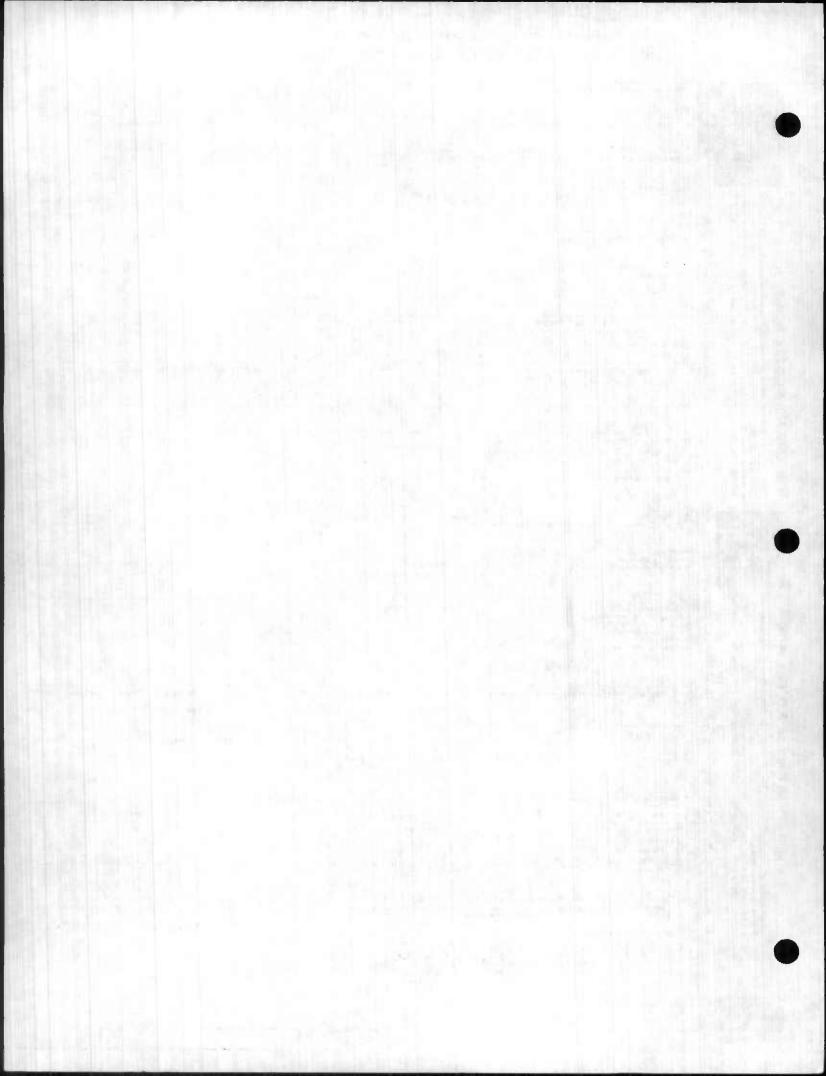
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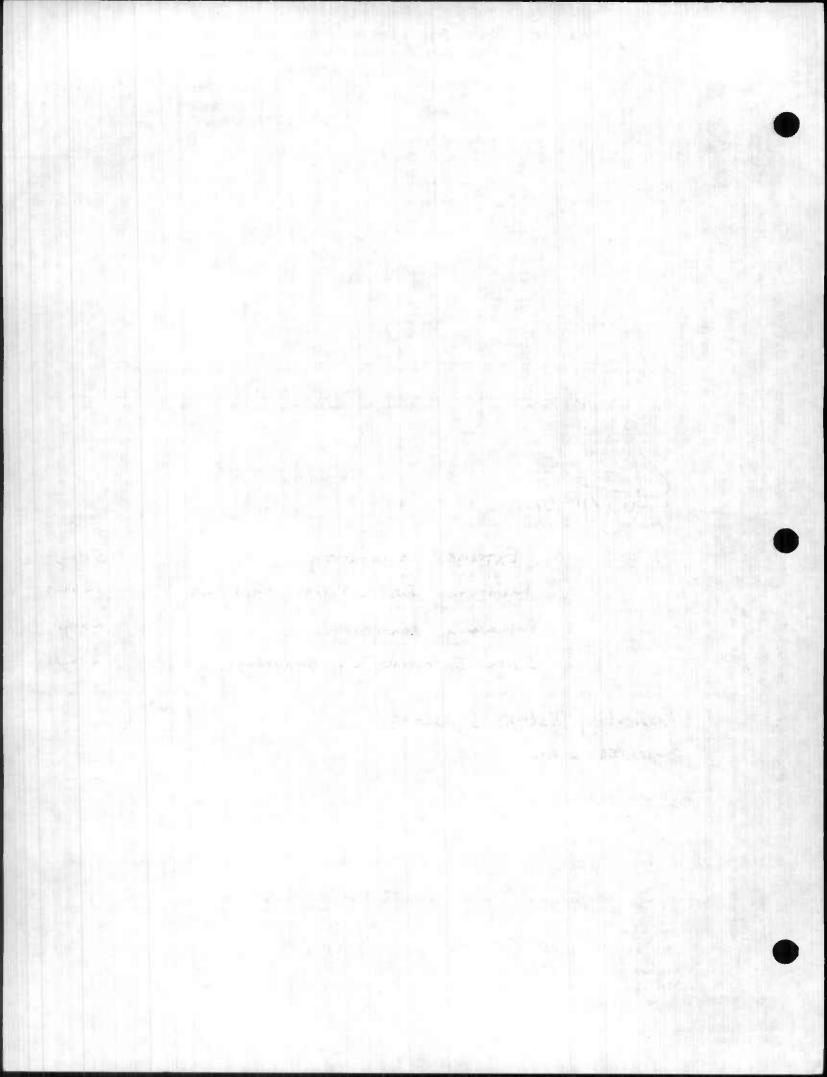
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	Examiner	5908 Ipswich R						Dathagi	1.	Manh			
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	or Herre 23 ziner must Furneral	11. Meritel Status		edent Ever in U	J,S. 13.	Wes Dece	dent of h	lispanic Origin?	(Specify Yes or I		eck, White,		
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7	THE MEST	George Franklin							M. Bell				
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	and selfment bear the	Tara Lynn Gilla	am		5908	Ipsw	ich	Road, B	Bethesda,				
e c	一工 単句	20a. Method of Disposition	a Damawattan		Pleca of Dispo cemetery, crei	netory or	me of other ple	ce)	Date	20c. Location	- City or To	wn, State	
Ĕ	Pages nent of net: If its ary or o	1 Buriel 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (S		Ga	te of I	Heave	n Ce	meterv	9/30/00	Silver	Sprin	g, MD	
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Division of	tal or Attending Phy is after death. al Director: After this led in by the funeral Certification: T	4 ☐ Homicide determ	nined 286. Plece build	of injury - At hing, etc. (Speci	fy)	reet, tactor	ry, onice			Town, State)	iber of Hore	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1001,
	To the Hospital or I within 24 hours after Yo the Funeral Direct Completely filled in b Medical Certi	29a. Certifier (Check only one) (Check only one) (Check only one)	ng Physician: To the Examiner: On the b	best of my kno asis of examine ner stated.	owledge, deat etion and/or in	h occurred	at the ti	me, date and plopinion, death o	laca, end due to the	ne ceuse(s) and r e, date and plece	nenner es s	tated. the ceuse(s	s)
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		30. Name and address ot person											
		M. Markwell, MI				cal C	ente	r , Bet	hesda, M	D			
	State	31. Date filed (Month, Day, Year)		legistrar's Sign	eture								

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

			C	ertitica	ite of	Death		Reg. No						
District Co.	1. Decedent's Name (First, Middle, Li	est)			D.O.		2. Date Mon	of Death th Da	v Y	a. T	ime of Death			
Physician /Modica	1.()(-AN	EARL V	WHEELER					TEMBER			3:33 PM			
/Medica Examine	4a Englis, Nama (16 mas institution of	ve street and number)	-41-4			4b. City, Tow	m, or Location of	Death 4c	. County of	Death				
Examine.	SHADY GROVE	ADVENUT	ST HOSDI	דע אד.		POCI	KVILLE	MC	ONTGO	MERY				
Funeral			e (In yrs. last birthde	y) If Und	er 1 Year	If Under 2	4 Hrs. 8. Date				State or Foreign			
Director	NONE	1₽M 2□F	Yrs.	Month:	Days	Hours	Min. (Mon	of Birth th, Day, Year) 19, 20	000	Marylar	nd			
	Usual Residence of Decedent						pope		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
and and	10a. State 10b. County		10c. City, Town or	Location		-				10d. Ins	ide City Limits			
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	11. Marital Status	12. Was Decedent Armed Forces?	11.00	If Yes, sp	edent of the cify Cub	Hispanic Origi an, Mexican,	in? (Specify Yes Puerto Rican, e	or No-		American Ind White, etc.	an,			
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ours ours	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			-				-,,-	Whi	Lte			
To hours effer	15. Decedent's Elementery/Secondary (0-12)	ducation	(Gi	cedent's Us	vork done	during most	of working	16b. K	ind of Busin	ness/Industry				
	Elementery/Secondery (0-12)	College (1-4or 5	life	. DO NOT	use retire	id)								
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and Hygid		t)				18. Mother	's Name (First, I	Middle, Maiden	Sumeme)					
Maryland 2 should be file 6 should be file 7 is marked oth traumatic event	David Earl	Wheeler	, Jr.			Gina	E1	izabet	h	McKear	n			
should nd Men marke	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Addre	ss (Street	t and Number	or Rural Route	Number, City	or Town, St	ate, Zip Code)				
Mary tract	David E. Wheeler		her 193	18 Ta	tters	shall I	rive, G	ermant	own. I	MD 208	374			
Health Health Dem 27 ther tr	20a. Method of Disposition	, 01., 140	20b. Piaca of Dis	position //	ame of		Date			ity or Town, St				
Dealtimore, Maryland 4.14. permit. Pegas 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Medica.	1 ☑ Burial 2 ☐ Cremation 3 [cemetery, c				Sept	30						
Pe Imar	4 Donation 5 Other (Special		Gate of	Heav	en Ce	emetery	2000	Sil	ver S	pring,	Maryla			
permit. Departmin porta	21. Sociative of Echeral Service Counsee 22. Name and Address of Facility DeVol Funeral Home 10. F. Deer Park Dr. Gaithersburg, MD, 20877													
0 89778	23a. Parth. Enter the classes, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between													
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/Medical	Immediate Cause (Final	E								-	1			
Examiner	disease or condition resulting in death)	" EXT		em 4-	ruti	TY				120	ays			
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The law require ate hes been single 2 should	SuspecTED Sep	psis						performed?		available completi of death	on of cause			
e law														
= + 50 (1 ☐ Yes 2	No	1 ☐ Yes	2 No			
Physician: The I	25. Was case referred to medical examiner?				1.		of Death (Check	only one)						
- S 00 B	1 Yes 2 No	Hospital:	ent 2 ER/Outpa	tient 3 🗆 I	DOA Ot	her: 4 Nur	sing Home 5	Residence	6 ☐Other	(Specity)				
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Dafa I	4 Homicide	building, et	c. (Specify)				City	or Town, Stat	B)					
plts ours filled		hysician: To the best	of my knowledge de	ath occurre	vd at the ti	ime date and	Lolace, and due	to the cause/s	nam bos (s	ner es stated				
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	(Check only 2 Medical Exa	miner: On the basis of and manner st	exemination end/or								ause(s)			
thin the mple		and manner sta	Ited.	1 2	Oc Licen	ce number		29d Da	ate signed /	(Month, Day,)	(ear)			
P. S. P. S.	M . el e e ma													
	1 addin	3225		Sept	ember	25, 2	000							
	30. Neme and address of person who	completed cause of d	eath (Item 23a) (Typ	pa, Print) 9	901 1	Medica	1 Center	Drive	, Roc	kville	, MD			
	30. Neme and address of person who	AM NEO	NATOLO	94, 5	HAD	4 GRO	ve adv	ENTIST	Flos	PRAL	20850			
State	21 Date filed (Month Day Year)	-	ar's Signature			,								
- State	SEP 2.9 2	1 / wal	wed 19	A.	200 W	11								



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** RUBY SEPTEMBER 22,2000 GENEVIEVE WATKINS 6:20 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WILSON HEALTH CARE GAITHERSBURG MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay. Year) DEC .28, 1913 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 25 F Months Days Hours MARYLAND 215 62 5286 86 Yrs Director Usual Residence of Decedent 10a. State 10b. County notified at 10c. City. Town or Location 10d. fnside City Limits VA. LOUDOUN HAMILTON 1 XYes 2 No Director 94 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? na 23s or 7 25 HAMILTON TERRACE DRIVE 20158 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, alc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give' Year or Datas: Baltimore, Maryland 21215-0020 b 1 ☐ Yes 2 No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Hygiena. College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) pounit, Pages 1 and 2 should be file Department of Health and Mental Hy important: If 1tem 27 is meries often any Injury or other traumatic event 8058. 18. Mother's Name (First, Middle, Maiden Surname) Be **GEORGE** BRIGHAM ELIZABETH CARTER 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) RONALD L. WATKINS, SON 25 HAMILTON TERRACE DRIVE, HAMILTON, VA. 20158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State KEMPTOWN CEMETERY 9/26/00 KEMPTOWN, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee 20 Name and Address & BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical WECK onchit Examiner Due to (or as a consequence of): Examiner The law requires that the deeth certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Box 68760. physician Physician/Medical Due to (or as a consequence of) 60 nse i P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ page 2 should Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? After this certificate hes 1 Yes 2 1 No 1 □ Yas 2 □ No Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how Injury occurred 28c. Injury at Work? 1 Neturel 5 Pending investigation Attending al or Attending a after death. 1 Yes 2 No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 4 | Homicide To the Hospital of within 24 hours at within 24 hours at to the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

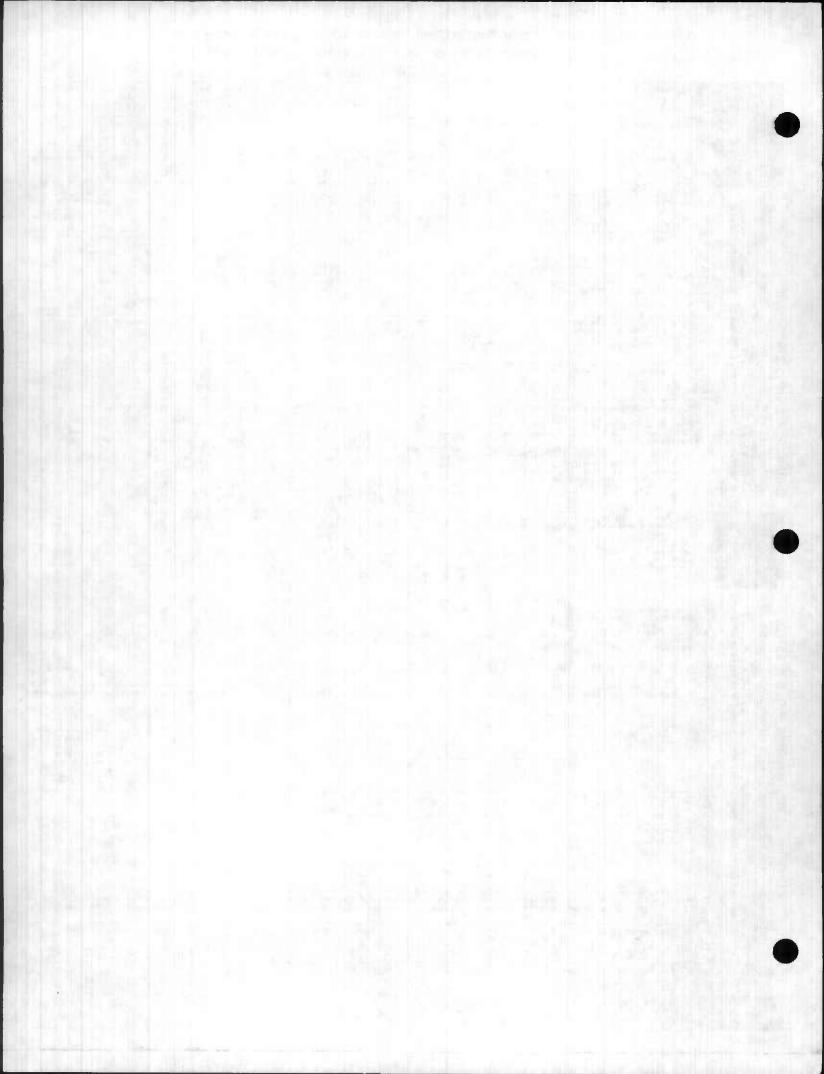
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and tipe of certif 29c. License number 29d. Date signed (Month, Day, Year) mi 2000 Juna Dep 30. Name and address of person ed cause of death (Item 23a) (Type, Print) Steven H. DOLINSKY, Gaithersburg usse 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 25 2000 Senew Registra

DHMH 16 Rev 6/95



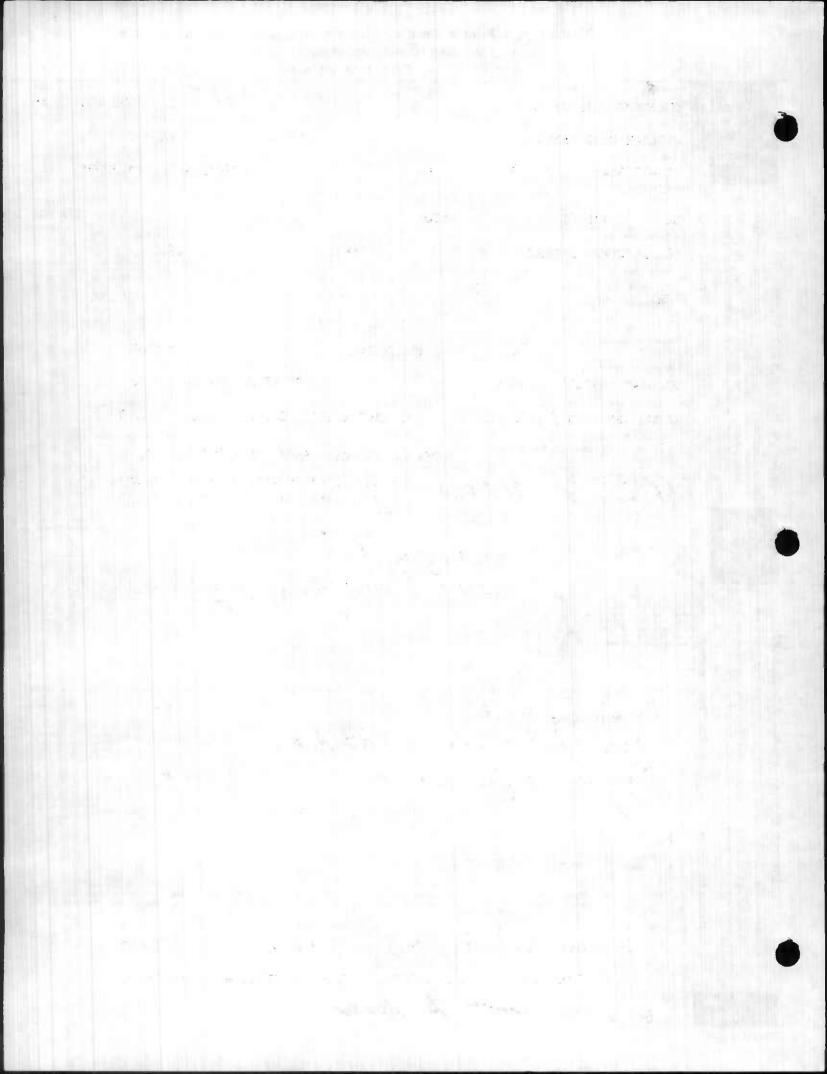
State of Maryland / Department of Health and Mental Hygiene

			Certific	ate of L	Death	R	eg. No.	32079
4	1. Decedant's Nama (First, Middla, Last)					2. Date of Dear Month	th	3. Time of Death
Physician /Medical	Marshall Walle	r				Sept.		000 10:50 Pm
Examiner	4a Facility Nama (If not institution, giva			4	b. City, Town, or L	ocation of Death	4c. County of	f Death
	Manor Care Potoma	С			Potomac		Montg	omery
Funeral Director	420-32-0036	7. Age (In yrs.	80 yrs.	hs Days	If Undar 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb 29	Year) 1920	9. Birthplaca <i>(Stata or Foreigr Country)</i> I L
pug *	Usual Rasidence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Location					10d. Inside City Limits
Sa-f sho			nevy Chase					1 ☐ Yes 2 ☐ No
Office the matter of the Mark the Mark the Mark the mettles of the mettles of the Mark the Ma	10e. Street and Number 8100 Connecticut	Ave.		Zip Coda 20815		1	Og. Citizen of Wh United	
urs surs surs by	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 (≛Yas 2 □ No If Yes, Give WW – II Year or Datas:	If Yes,	ecedant of Hi specify Cuba s 2 ☐No	ispanic Origin? (Sp n, Mexicen, Puerto Specify:	ecify Yas or No- Rican, etc.)		- Americen Indian, , White, atc. te
Ind 21215-0020 be filed within 72 hours at lai Hygiene. d other than 'naturel', or event, the Medical Exact Be Completed by F	15. Decedent's Edui (Specify only highast grade Elamantary/Secondary (0-12)	cetion completed) College (1-4or 5+)	16a. Decedent's L (Give kind of life. DO NO Officer	Jsuel Occupa work done of Tuse retired	during most of world	sing	16b. Kind of Busi Militar	iness/Industry cy / Army
Hygie C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middla, I	Maiden Sumeme,)
should be filed and Mental Hygin marked other Imatic event, I To Be Co	James Waller					Goldberg		
Maryland d 2 should be file lith and Mental Hy 27 is marked othe treumatic event To Be (19a. Informant's Name/Relationship (Type Sylvia Waller /Wi				and Number or Ru			
Baitimore, Nemit. Pages 1 end Department of Health moortant: If item 27 my Injury or other the	20a. Mathod of Disposition 1 Burial 2 Cramation 3 R	20b. F	Place of Disposition (cematary, crematory	Name of		Sep 26	20c. Location - C	City or Town, Stata
timor thent of thent: If its	4 Donation 5 Other (Specify)	CI	hesapeake			2000		lle, MD
Baitile permit. F Departmenting important eny Injure	21. Signature of Funeral Service Ligener	40 Vett			eral & Cr Avenue	emation Silver	Service Spring,	s MD
Physician	23a. Pert1. Enter the disease or compli- shock, or heart failure. List only or	cations that ceused the deat a cause on each line.	h. Do not enter the r	mode of dyin	g, such es cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition	Pnuemonia						5 days
in the same of	rasulting in death)	Due to (c	or as a consequence	of):				
secuted end si-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying	Due to (o	or as a consequance	of):		TALE		
68/60, tificate be executed g physician and as the bunal-transit	ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Last	Due to (o	or as a consequance	of):				
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beath cert ettendin of for use	Dad II Other elanitional conditions con	telbuting to doub but not upo	ulain a in the condesi.		on in Rod I	nah Dida	haces use cont	tributa to the cause of death
ires that the death certifies that the death certified by the ettending to be deteched for use at by Physician/M	Part II. Other significant conditions con	Induting to death but not res	uning in the underlying	ng ceuse givi	en in Parti.			3 Probably 4 Unknow
aw requisite to the second of						24a. Was a perfor	in autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
The lay						1 🗆 Y	es 2DNo	1 ☐ Yes 2 ☐ No
yaiclan: The la yaiclan: The la s certificate he director, page	25. Was case referred to medicel					th (Check only or	na)	
Of VICE Physician: this certific ral director,	1 Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient 3		4 Linursing H	ome 5 Resid		
Invision of vital or Attending Physician: 1 after death. In by the funeral director, po	27. Manner of Death 1 Natural 5 Pending 2 Accidant investigation	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	yat k? Yas 2□No	28d. Describe h	ow injury occurre	d
UNISION C be or Attending P is after death. of Director: After t led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicida datarmined	28a. Place of Injury - At he building, atc. (Specification)	ome, farm, straet, fac (y)	ctory, office		28f. Location (S City or Town	treat and Number n, State)	r or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely lilled in Medical Cert		ician: To the best of my kno er: On the basis of examina and manner stated.						
within To the compl	29b. Signature and title of certifier			29c. License	a number	2	9d. Date signed	(Month, Day, Year)
1+65	Sayuba Mw		00-1/7	D5520	0		September	2 25, 2000
	30. Name and address of person who co Murthy Sangeetha			., Ger	mantown,	MD 2087	4	
State	31. Data filed (Month, Day, Year)	32/Registrar's Signa		a V				A PERM



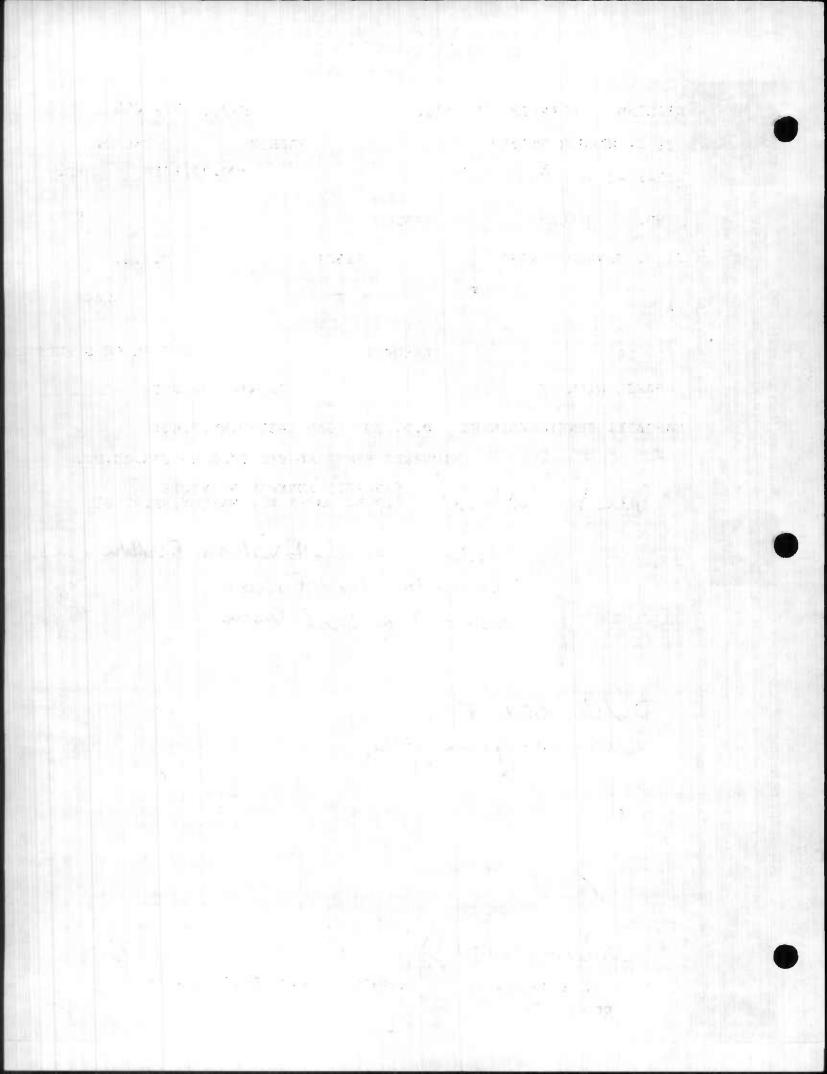
State of Maryland / Department of Health and Mental Hygiene 00 32080

					Cei	rtificate	of	Death			Reg. No.		02000
	Obvolelen	1. Decedent's Name (First, Min	iddle, Last)							2. Date of De		Year	3. Time of Deeth
-	Physician - /Medical	CHARLENE LATH	ROP WHITE							Month 09		2000	5:10 AM
	Examiner	4a Facility Name (If not Institu WILLIAM HILL		um <i>ber)</i>				4b. City, Tow EASTO		ocation of Deat			
	Funeral Director	5. Social Security Number 216–12–0649	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. las	st birthday) 38 Yrs.	If Under 1 Months	Year Days	Hours	4 Hrs. Min.	8. Date of Bit 08/02/	T912		
	pue *	Usual Residence of Decedent 10a. Stete 10b. Cour	nty	10c. City,	Town or Lo	cation							10d. inside City Limits
	death with the Menylend ms 23e or 28e-f show rmust be notified at neral Director	MD TALB	вот	EAST	ON								1 X Yes 2 □ No
	or 28	10e. Street and Number				10f. Zip C						What Cou	ntry?
	23a rail	501 DUTCHMAN'				216							
	urs effer death with the Me sil, or Nems 23s or 28s-fa Xaniner must be notified by Funeral Director	11. Maritel Status 1 ☐ Never Married 2 ☐ M	Armed	cedent Ever In U.S. Forces? 2 X No			_		n7 (Sp Puerto	ecify Yes or No Rican, etc.)	Bla		
020	72 hours efter neturel; or ite dreat Exeminated by Full	3 Widowed 4 □ Divord	16 1/ /	ive		1□ Yes 2	No.	Specify:			Speci	か: WHI	TE
5-0	"natural", adral Exi		dent's Education		16a. Deced	dent's Usual kind of work	Occup	pation during most of	of work	ing	16b. Kind of I	Business/Ir	ndustry
21215-0020	- 1 -	Elementery/Secondery (0-12		(1-4or 5+)		MAKER	retire	d)			OWN HO	ME	
Maryland	should be filed within and Mental Hygiene. marked other than marke event, the M. To Be Comp	17. Fether's Name (First, Midd WILLIAM BURRE		P							ER YOCU		
	Heelth end 2 sho Heelth end am 27 is me ther traum	19a. Informant's Name/Relation		TER									p Code)
Baltimore,	S - E	20a. Method of Disposition 1 XBurial 2 Cremetic 4 Donation 5 Other		n State Cerr	netery, crer	natory or oth MEMOF	er pla	ca) L PARK	9	Date 9/25/00			own, State
Balti	permit. Page Depertment of Important: If any Injury or once.	21. Signature of Funeral Servi	ice Licansee	(FSP				HELFEN					
	•	23a. Part : Enter the disease shock, or heart failure.	, or complications that	t caused the death.							-		Approximete
4	Physician			0		0	/	7					Onset and Death
	/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	a(ardios	erue	Lu	rl						Why
	12000	Toolang in down,	Δ	Due to (of	s e consec	quence of):	1/	1. N	1	Cons	1 - 11	11	1
	d ansit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Altho with Original Consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										au	14
90,	ing physician end es the bunal-transit Medical Examin	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events								Pour	une	İ	
68760,	physic the b	that initiated events resulting in death) Last	С.	Due to (or a	s a conseq	juence of):							
ox 6	thet the death certificete be executed ed by the ettending physician end detached for use as the burial-transit Physician/Medical Examir		d										
œ.	death le etten ed for u	Part II. Other significant cond	litions contributing te	death but not resulti	ing in the u	nderlying cau	use gir	ven in Pert I.		23b. Dfd	tobacco use c	ontribute	to the cause of death?
P.0	es thet the death c igned by the ettend be detached for us by Physician.	Rosenh	hin dry	tuo						1	Yes 20 No	3 Pro	obably 4 Unknow
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Vital	certificate rector, peg	25. Was case referred to med examiner?	1.1				100		of Deat	th (Check only	one)		
of	4 5 B	1 Yes 2 No			R/Outpatier			400 Nur	sing Ho				ity)
on	ding i h. After fune fune	Naturel 5 Per	/4.4.	onth, Day Year)	Injury	м 23	c. Inju Wo	rk? Yes 2∐N	lo	200. 00001100	now injury cook	2000 5:10 AM 4c. County of Death TALBOT 9. Birthplace (State or Foreign MTSSOURI 10d. Inside City Limits 1 Yes 2 No 9. Citizen of What Country? J. S. A 14. Raca - American Indien, Black, White, etc. Specify: WHITE 6b. Kind of Business/Industry 20WN HOME aiden Sumame) R YOCUM City or Town, State, Zip Code) CA 92010 0c. Location - City or Town, State ASTON, MD AM FUNERAL HOME N, MD 21610 st, Approximate Intervel Between Onset and Death Color of Completion of Cause of death? 20 No 3 Probably 4 Unknow 1 autopsy ed? 24b. Were autopsy findings available prior to conset and Death Color of Cause of death? 2 No 1 Yes 2 No	
Division	or Attending after death. Director: Afte in by the fune ertificatior	3 Sulcide 6 Cou	ald not be 28e. Pla	ca of Injury - At hom ding, etc. (Specify)	ie, ferm, str	reet, factory,	office		1	28f. Location City or To	(Street and Num wn, Stete)	nber or Ru	ral Route Number,
_	To the Hospital or Attending Ph within 24 hours abter death. To the Funeral Director. After thi completely filled in by the funeral Medical Certification: 7	29a. Certifier 1 Certifier (Check only one) 2 Medic	cal Examiner: On the	ne best of my knowle basis of examination	edge, death n end/or in	n occurred at vestigation, i	the ti	me, date end opinion, death	placa,	and due to the red at the time	cause(s) end r date and place	nanner as e, and due	stated. to the cause(s)
	To the comp	29b. Signature and title of cert	am Ha	loud a	MO	29c.	Licen	se number	715		29d. Date sign	. /-	, Day, Year)
		30. Neme and eddress of pers WILLIAM H. W					LAN	NE EAS	STO	N, MARY	LAND 21	601	
	State Registrar	31. Date filed (Month, Day, Ye SEP 2 5 20		Registrar's Signatu	9. 19	park	2						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 3 2 0 8

							(Certifica	te of	Death		Reg.	No.		C 0 0 1
			1. Decedent's Name (I	First, Middle, La	st)						2. Date of I	Death		ear	3. Time of Death
	Physiciai /Medica	a1 -	WILLIAM te Fecility Neme (If no		RLES	WILK	INS			4b. City, Town,	SEPT or Location of De		25,200 4c. County of	00	6:007
	Examine	er			STREET	~,									
_	Funeral		21 S • H. 5. Sociel Security Num			Age (In yrs.	lest birth		er 1 Yea		rs. 8. Date of	Birth	TAI	BO' Birthpl	ece (Stete or Foreig
	Funeral Director		215-18-4 Usuat Residence of De	189	X M 2□F	82	Yr	s. Month	Deys	Hours N	in. 8. Date of (Month,	29, Ye	1918	Count	MD.
	dend we	-		b. County		10c. Ci	ty, Town	or Location						10	0d. Inside City Limits
	leath with the Merylen rs 23s or 28s-f show must be notified at	Director	MD.	TALB	ОТ		EAS	TON							11 Yes 2□No
	Mary Mary		10e. Street end Number	er					ip Code			10g.	Citizen of Wh	et Count	iry?
	a 23	20	21 S. HA	NSON S	TREET		10		2160		(Casalla Vanas	Ale	U.S. 7		an Indian
21215-0020	urs after o	by Fur	11. Marital Status 1☐ Never Married V☐ Widowed 4 [12. Wes Deced Armed Forc 1 Yes 2 If Yes, Give Yeer or Det	es? D X No	1,8.	13. Wes Dec			(Specify Yes or erto Rican, etc.)	NO-		White, e	etc.
2-0	72 hours	Completed	(Specify	. Decedent's Ed	ducation		16e. D	ecedent's Us	ual Occu	ipation	working	16b	. Kind of Busi	ness/Ind	ustry
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Mary	2 sh and le rr raurr		19a. Informent's Name	/Relationship (Type, Print)		19b. F	Aailing Addre	ss (Stree	et end Number o	Rurel Route Nur	nber, C	ify or Town, St	lete, Zip	Code)
6	and leelth m 27 her t		MARGARET		NS/SIST	CER	P. C	. BO	16	65 EAS	TON MD	.21	601		- 01-1-
Baltimore	Pages 1 nent of H int: if Iten iry or oth		20a. Method of Dispos 1 Tr Burial 2 0 4 0 Donetion 5 I	remation 3		ate	cemetery,	cremetory of	other pi	ace)	K 9/30,				
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00			23a. Pert1. Enter the shock, or heert for	diseese, or compilure. List only	plications that cau	used the dee	th. Do no	319 I	ode of dy	OVER S ring, such es care	T. EAS'	ron y errest,	, MD. 21	1601	Approximate tntervet Between
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	5 00	5	resulting in death) Les		d	201010	5. 00 0 00		,					i	
Вох	d for use	Physician	Part II. Other significa	nt conditions o		th but not ro	oulting in t	he underbind	Called	iven in Part I	23h D	id toba	cco use conti	i ibute to	the cause of death
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0	th. After a funer	9	1 Naturel	Pending investigation		Dey Year)	Inji	Iry M		onk? Yes 2 No					
Division	after death. Director: After din by the function	Certification:		Could not be determined	28e. Placa o	f Injury - At h , etc. <i>(Speci</i>	nome, farn	n, street, facto	ory, office			n (Stree Town, S		or Rura	/ Route Number,
	To the Hospital or Attending R within 24 hours after death. To the Funeral Director: After completely filled in by the funer				ysician: To the b										
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	To t To t	2	29b. Signeture and title	of certifier	.11	Λ (1	2	9c. Lice	nse number		29d.	Date signed	(Month,	Dey, Year)
			//	Wian	Hu	and !	1		10	00871	5		9/2.	7/6	Cot
			30. Neme end eddress	of person who	completed cause	of deeth (Ite	m 23e) (T	ype, Print)					•		
			WILL	AM WOO	OD, JR.	MD 50)5 D	UTCHM	ANS	LANE	EASTON,	MD.	21601		
	State	e	31. Dete fited (Month,	Dey, Yeer)		gister's Sign		4	1						
	Pagietra	_	9	FP 9 7	/IIIII .	Lance	-	47	Ann	1. 1. 1					



					State of M	larylan		epartment of Certificate of		and Mental H	ygiene U	U :	32082
10	Physician /Medical Examiner	R	lich	(First, Middle, Lasi QM M not institution, give	Wil		5		4b. City, To	2. Date of E Month OC 7 wn, or Location of Dec	04 2	Year 2000 of Death	3. Time of Death
	Funeral Director	Howa 5. Social S	ecurity Nu -01-0	805		spital ge (In yrs. 81		Months Da				9. Birth	place (State or Foreign ntry) New Jersey
	Maryland -f ahow	10a. Stete	idence of	10b. County Howard			y, Town o	or Location					10d. Inside City Limits 1 ☐ Yes 2 ☐XNo
	ifier death with the Mai r flore 23a or 284 a niner must be notified Finneral Director	10e. Street			ad			10f. Zip Coo			10g. Citizen of V	What Cou	ntry?
020	by	3 □ Wi	Status wer Merrie	d 2 🔯 Married	12. Was Deceden Armed Forces 1 X Yes 2 If Yes, Give Year or Dates	? No	,S.	13. Was Decedent If Yes, specify C		gin? (Specify Yes or N , Puerto Rican, etc.)	No- 14. Rac Bla Specify	ck, White,	can Indian, , etc. ite
21215-0020	within sne.	Element	(Specil	15. Decadent's Edu y only highest grad dary (0-12)	ucation le completed) College (1-4or	5+)	(6)	ecedent's Usual Oc Give kind of work do He. DO NOT use re K Informa	ne during mos tired)		16b. Kind of B		
Maryland 2	d off	17. Father		irst, Middle, Last) M. Wilki		2.0	10.		18. Mothe	r's Name (First, Midd Virginia	lle, Maiden Surnan Roge		
		Fr	ances	me/Relationship (7)		204 5	791:		Road L	aurel, MD	20723		
Baltimore,	Pages nent of int: If its irry or o	4 🗆 D	urial 2 s	Cremation 3 III		9	em <i>etery</i> ,	crematory or other Crematory 22. Name end Ac	, Inc.	10/5/00		svill	
Ba	permit. Departrimporturany injing	23a. Pert	Alle	to X	MO1:		h. Do no	Donaldso	n Funer	cal Home, I	P.A. Laur		MD 20707
	Physician /Medical Examiner	Immediate disease or resulting in	e Cause (F	inal	a. Phe	mov	lio	nsequence of):	-	cerdiac or respiratory			intervel Between Onset and Death
x 68760,	that the death certificate be executed sed by the attending physician and detached for use as the bunal-transit by Physician Medical Examiner	Cause (Di	sease or in	njury	b			nsequence of):					
, P.O. Box	v requires that the death certifica been signed by the attending ph should be detached for use as the should by Physician/Median/Median	Part II. Oth	er signific	cant conditions co	ntributing to death	but not res	oulting in t	he underlying ceuse	given in Part I		id tobacco uss co □ Yes 2□ No	ontribute	to the cause of death?
of Vital Records,	The taw requires the sale has been signed page 2 should be decompleted by	Pa	rki	nson's	Disea	se				24a. W	es an autopsy normed?	a	Vere autopsy findings vailable prior to ompletion of cause f death?
ital Re	iclan: The law certificate has brector, page 2 s	25. Was co	ese referre	ed to medicel					26. Place	1 [of Death (Check on)	Yes 2500	1	☐ Yes 2☐ No
Division of V	this aldi	1 ☐ Ye	or of Death atural ocident	5 Pending Investigation 6 Could not be determined	200. PIACE UI II	ury ay Year)	28b. Tin Inju	ne of 28c.	Injury at Work? 1 ☐ Yes 2 ☐	No 28f. Location	e how injury occur in (Street and Num. Town, State)	rred	
Ö	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification	29a. Certil (Chec	fier		sician: To the bes	t of my kno	wledge, o			d place, and due to the	ne cause(s) and m		
	To the comple		etuje and t	ifle of certifier	2	X	- W	29c. Lic	cense number	74	29d. Date signed	od (Month	Day, Year)
		30 Name	and addre	ss of person who c	ompleted cause of	death (Iter	n 23a) (T	ypa, Print)	10	and Co	NA HACA	C	lumbio, MD

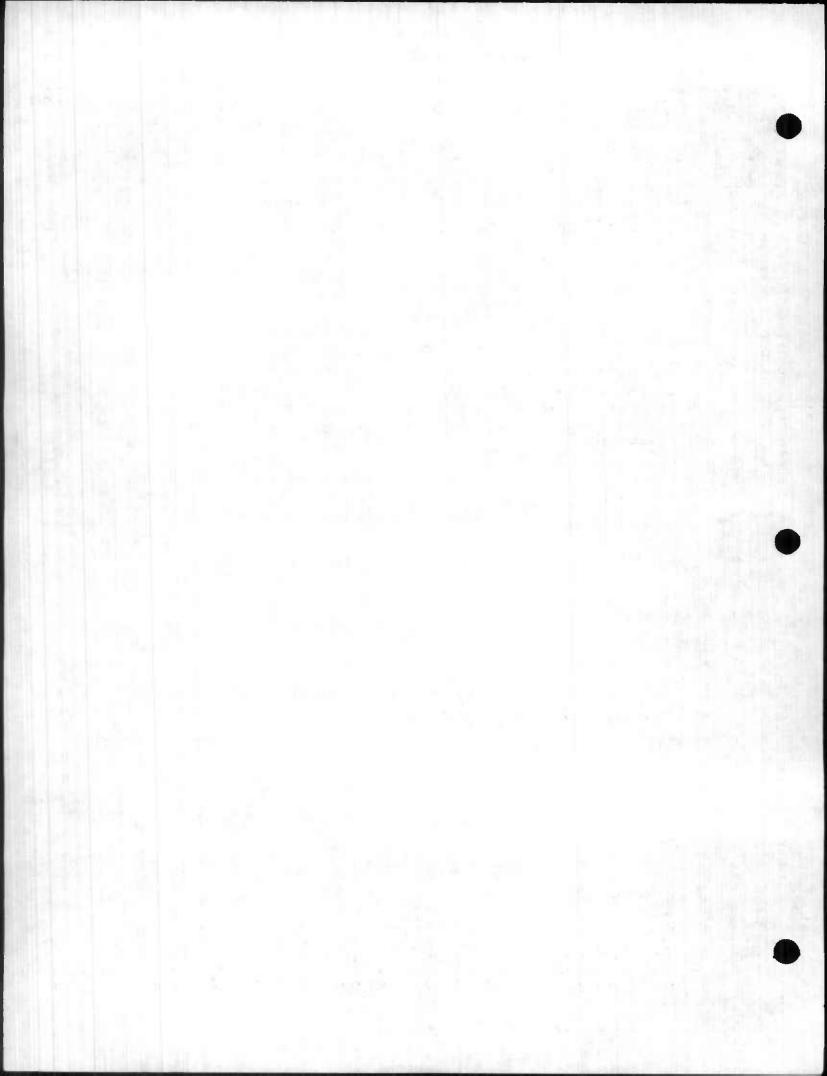
State Registrar

OCT 0 6 2000

Michael ESIVEMAN, MD

31. Date filed (Month, Day, Year)

32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dey Yes Month **Physician** Elaine Cecilia Wilhelm 06:58 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner 4c. County of Deeth Allegany Frostburg Village Nursing Care Center Frostburg If Under 1 Yeer If Under 24 Hrs. Months Deys Hours Min. 8. Dete of Birth (Month, Dey, Ye. 08-May-20 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 9. Birthplece (State or Foreign Months Maryland 213-12-9743 80 Director Usual Residence of Decedent with the Maryland 10b. County or 28a-f show 10c. City Town or Location if Haalth end Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Monical Experience must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Allegany Frostburg 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? **40 Locust Street** 21532-U.S.A. end 2 should be filed within 72 hours after death a saith end Mentat Hygiene. Funeral 11. Maritel Stetus 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Maryland 21215-0020 1 Yes a No Specify: þ Specifyhlte 3 Widowed 4 □ Divorced Year or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker 12 Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) Be 2 **Anderson James Green** Mary Veronica Monahan 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is Patrick D. Wilhelm Son Frostburg Maryland 40 Locust Street Baltimore, Pages 1 e 20a. Method of Disposition 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete permit. Pages Department of Important: If its eny injury or o cemetery, cremetory or other place) 8 Burial 2 ☐ Cremation 3 ☐ Removal from State Frostburg Memorial Park 20-Sep-00 Frostburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service License 22. Name end Address of Fecility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Dent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician MYOCARDIAL INFARTION CONE HOUR to (or es e consequence of): 9RY ARTERY DISZASE >5 YEARS Immediete Ceuse (Finel diseese or condition resulting In death) /Medical Examiner The law requires that the death certificete be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Box 68760, ettending physician for use as the buria by Physician/Medical Due to (or es e consequence of) signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown DIABETE MELLITES Completed ALZHZIMERS DEMENTIA 24e. Wes en eutopsy performed? 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? page 2 s has Division of Vital 1 Tyes 2 NO NO 1 Yes 2 No or Attanding Physician: funeral director, Be 25. Wes case referred to medical exeminer? 26. Plece of Death (Check only one) Hospitel: Certification: To 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred After 1 Naturel 2 Accident 5 Pending efter death.

Director: Aff
d in by the fur Investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Filled within 24 hours Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Neme end eddress of person with completed cause of death (Item 23e) (Type, Print) THE Chang-Hyun Oh, M.D., 48 Tam Terrace, Frostburg, Maryland 21532 32. Registrer's Signature 31. Dete filed (Month, Day, Year SEP 1 8 2000 State Registrar

DHMH 16 Ray 6/95

ANTERPE 2000 TELEPINE DateOfter(1) From Videos Harmer Care for lot DOSTORY DESCRIPTION Meryland Allegany CHOROLL I them sayout or 2.532 oticle insumemohi. Non-Vereilled Monat an to no son id nos on de Local free Fostburg Mondona 2151. Family E. Wilhelm thornow employ 00-qn2-ys Rosaburg Memoral Rad.

Detail Fundral Holine, 37 Fros. Ave., from Pring, 530, 213, 2

The first Ch. M.D. 45 Ten. Teneral troofburg 1929 and 11532

Some Ceclio Winelm

Physician /Medical Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28s-f show eny injury or other treumatic event, the Medical Examinar must be notified at page.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

edical Examiner been signed by the attending physician and should be detached for use as tha burial-transit

To the Hospital or Attending Physician: The law requires that tha death certificata be assecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as tha bunsi-transit 10 nus

Division of Vital Records, P.O. Box 68760,

	State of	maryian		eparimen Certificat				Nental Hyg	gierie Reg. No.	UU	32084
1. Decedent's Nama (First, Mide	dle, Last)							2. Date of Dea			3. Time of Death
GEORGE RAYMOI	ND WERTZ							SEPTEMBE	ER 17 2	000	7:13PM
4e Facility Neme (If not institution		ber)			1	lb. City, To	wn, or L	ocation of Death	4c. Count	ty of Death	
FROSTBURG VIL	LAGE NURSIN	IG HOME				FRO	STBU	RG	ALL	EGANY	
5. Social Security Number		. Age (In yrs.	last birthd	(ay) If Under		If Under		8. Date of Birth	h	9. Birth	place (State or Foreign
214-07-1228	1 M 2□ F	91	Yrs	Months	Deys	Hours	Min.	8. Date of Birth (Month, Day APRIL I	2 1909	Cou	PA.
Usual Residence of Decedent											
10a. State 10b. Count	у	10c. Cit	y, Town o	r Location							10d. Inside City Limits
MARYLAND AL	LEGANY	C	UMBEI	RLAND							1 ☐ Yas 2 ☐ No
10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	ntry?
1727 BEDFORD S	TREET			2	1502	2			U.S	.A.	
11. Merital Status	12. Was Deced	dent Ever in U	,S. 1	13. Was Deced	dent of H	ispanic Or	igin? (Sp	pecify Yes or No-		ce - Ameri	can Indian,
1 Never Married 2 Ma		No No		1 ☐ Yes		Specify		, , , , , , , , , , , , , , , , , , , ,	Speci		HITE
3 ☑ Widowed 4 ☐ Divorce	d Year or Da	las:		10 100	201140	ороспу.			Зресі	ny. v	IIIIE
15. Decede (Specify only high:	nt's Education ast grade completed)		(G	ecedent's Usua Give kind of wo	rk done	during mos	it of worl	king	16b. Kind of E	Business/Ir	ndustry
Elementery/Secondery (0-12)	1	4or 5+)	111	le. DO NOT u	se retired	9					
8			MANA	AGER AL	LSTA			ERY CO.			HOLESALE
17. Fathar's Name (First, Middla								e (First, Middle,	Maiden Surna	me)	
WILLIAM WALT	ER WERTZ					EFF	IE O	STER			
19a. Informant's Name/Reletion PEGGY HUGHES	AUTHER		lailing Address				ral Route Numbe E, MARYI		n, State, Zi 21502		
	Granddau	ahter		isposition (Nar				Date	20c. Location		
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other (0	emetery.	CEMETE:	ther plac	EPT 1	3 20				MARYLAND
21 Signature of Funeral Service				22. Name an	d Addre	ss of Facili	tv				
D 9	N at	-						RAL HOM	E P.A.		
Note of.	Herris							CUMBER		RYLA	
23a. Pert1. Enter the diseasa, of shock, or heart tellure. Lis	or complications that ca at only one ceuse on ee	used the deat ch line.	h. Do not	enter the mod	e of dyln	g, such es	cardiac	or respiretory an	rest,	1	Approximate Interval Between Onset end Death
		~ 1								1	Criser end Death
Immediate Ceuse (Finel disaese or condition		and	wix	Aelle	reig					1	10 years
resulting in death)	<u>a</u> .	Due to (c	or as a cor	sequence of):		-	100	1111		1	
Sequentially tist conditions, if any, leeding to immediate	D	Due to (o	r as a con	sequence of):						1	
cause. Enter Underlying										i	
Ceuse (Diseese or injury that initiated events resulting in death) Lest	C	Due to (o	r es a con	sequence of):						1	
rosoning in Godin/ Lost	Today =									1	
	d									1	
Part II. Other significant condit	lons contributing to des	ith but not res	ulting in th	ne underlying o	ause niv	en in Part	t.	23b. Did t	obacco use o	ontribute t	to the cause of death?
. 1				,,	y"			400		2 D D-	

that initiated events resulting in death) Lest	Due to (or es a consequence of	n):			
Part II. Other significant conditions co		sulting in the underlying	cause given	n Part t.	23b. Did tobacco use co 1 ☐ Yes 2 No	ontribute to the cause of death? 3 Probably 4 Unknow
Denente					24a. Was an autopsy performed?	24b. Were autopsy tindings available prior to completion of cause of death?
					1 ☐ Yes 2 🏋 No	1 ☐ Yes 2 ☐ No
25. Wes case reterred to medical examiner?	Hospitel:		Other	15.5	eeth (Check only one)	
27. Manner of Death 1 Neturat 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of tnjury M	28c. Injury at Work?		Home 5 Residence 6 Ott	
3 Suicide 6 Could not be determined	28e. Place of Injury - At the building, etc. (Special Control of the control of t	nome, ferm, street, tect	ory, office	141	28f. Location (Street and Numi City or Town, State)	ber or Rural Route Number,
29a. Certifier (Check only one) 1 € Certifying Phy 2 ☐ Medical Exam	raician: To the best of my kn iner: On the basis of examin and menner steted.	owledge, death occurre ation end/or investigation	ed et the time, on, in my opini	date end place on, deeth occ	e, end due to the cause(s) end m curred at the time, date and place,	enner es stated. and due to the cause(s)
29h Signeture and title of certifier		1 2	9c License n	ımher	29d Date sinns	ad (Month Day Year)

MO 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) SETON DRIVE

DR GEORGE BREZA 912 31. Date tiles Ep 19 2000

29b. Signeture and titla of certified

32. Registrar's Signature

CUMBERLAND MARYLAND

29c. License number D 12532

29d. Date signed (Month, Day, Year)

SEPTEMBER 18, 2000

State Registrar

1931 4

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State of Maryland / Department of Health and Mental Hygier Certificate of Death 2. Dete of Deeth 3. Time of Death 1 Decedent's Neme (First Middle Last) **Physician** 09-19-2000 Mary Angela Weisenborne 3:07 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner FROSTBURG VILLAGE NURSING HOME FROSTBURG ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
APRIL 26 1912 MARY LAND 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthplece (Stete or Foreign **Funeral** 10 M 2 F Deys Hours Yrs. 88 Director 216 01 8834 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f ahow 7 is marked other than "natural", or itams 23a or 264-1 anon traumatic evant, the Westical Examinet must be notified at X Yes 2 No Funeral Directo MARYLAND FROSTBURG ALLEGANY 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S. 23 WASHINGTON STREET 21532 12. Was Decedent Ever in U,S. Armed Forces?, 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Meritel Status Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) SALES VARIETY STORE 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Peges 1 and 2 should be nent of Health end Mental ant: If Item 27 is merked o GERALDINE HUGHES HUGH DONAHUE 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) STEPHEN WEISENBORNE / GRANDSON 11435 ROWLEY ROAD, CLARKSVILLE, MD 21029 nt of Health e If item 27 is or other train 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State permit. Pege Depertment of Important: If any Injury or page. ST. MICHAEL'S CEMETERY 9/22/00 FROSTBURG. MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility
SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, Main stat caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, seuse on each line. FROSTBURG, MD 21532 Approximete Interval Between Onset and Death **Physician** Thyraid CARCinoma Immediete Cause (Finel diseese or condition resulting in deeth) /Medical Glar S Examiner Physician/Medical Examine Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760. Due to (or es e consequence of): P.0. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown á Division of Vital Records. by 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? Be Completed rain Syndrome. 1 Yes 2 LINO 1 ☐ Yes 2 ☐ No To the Hospital or Atlanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Manger of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28l. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner steted. 29a. Certifier 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signeture end title of cartifie Derlow Der 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) SATURN NA

State Registrar Sut 3

Creek S, W

32. Registrer's Signature

EFF 2 1 2002 Summer of Agreement

Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** WINGERT JOSEPHINE ELEANOR 9 9:40 AM 00 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Memorial Hospital & Medical Center Cumberland
If Under 1 Year | If Under 24 Hrs. 8.
Months Deys | Hours | Min. Allegany 8. Date of Birth (Month, Dey, Year, 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) **Funeral** 1□ M 2♥ F Country) MARYLAND 80 Yrs. JULY 27,1920 215-20-5713 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at MT. SAVAGE MD ALLEGANY 1X Yes 2 □ No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with b U.S.A. 21545 14014 MT. SAVAGE ROAD, N.W. Herna 23a Funeral 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Black, White, etc. 72 hours efter 1 Yes 27 No ff Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2√2 No Specify WHITE p 3√ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) WINGERT REGISTERED NURSE NURSING - HOSPITAL Department of Heelth and Mental Hygin Important: If Item 27 is marked other any injury or other traumatic event, III once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 and 2 should be WILLIAM N. BENNETT LILY RETZER 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ELEANOR 1717 BEDFORD STREET, CUMBERLAND, MD 21502 PENNY E. LOGSDON / DAUGHTER 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition 17 Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) CUMBERLAND, MD SUNSET MEMORIAL PARK 9/25/2000 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the deeth certificate be executed been signed by the attending physicien end should be detached for use as the bunal-tran Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ocherma angregosur that initiated events resulting in deeth) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Winknown 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Was an autopsy performed? Be Completed page 2 2 NO 1 Yes 1 Yes this certificate To the Hospital or Attending Physician: 25. Was cese referred to medical 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 ☐ Yes 2 100 1 Opatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? After 5 Pending investigation Naturel 1 Yes 2 No eral Director: A filled in by the f 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 | Homicide within 24 hours of To the Funeral I It ling Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29d. Date signed (Month, Day, Year) 29b. Signeture end title of ce lifier 29c. License number wo D0054426 SEPT. 22 2000 30. Name end eddress of person who completed oause of death (Item 23a) (Type, Print) nus MEN MED BLDG. 105, MICHAEL D. ZANG M.D. 500 MEM.AVE. CUMB. MD. 21502 32. Registrar's Signeture SEP 2 5 2000 State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DHMH 16 Rev 6/95

THE PARTY OF THE P SEP 2 1 2000

State of Maryland / Department of Health and Mental Hygiene 11 32187

				Cei	tificate of	Death		Reg. No.	, ,	2001			
	1. Decedent's Name (First, Midd	die, Last)		G Day	MINI I				Year	3. Time of Death			
ician dical	FRANCIS	BURNELI			WAGNER		9	190	2000	2120			
niner	4a Facility Name (If not Institution	on, give street and num	ber)			4b. City, Town	n, or Location of Dea	th 4c. County	of Death				
	PENINSULA REG	IONAL MEDIC	CAL CEN	ITER			SBURY						
al or	5. Social Security Number 176-05-2490	6. Sex 1 M 2 □ F	7. Age (In yrs. 79	last birthday) Yrs.	Months Days		Min. (Month, D	irth ey, Year) ,1921	9. Birthp Court PEN	lece (State or Fore try) NSYLVANIA			
20	Usual Residence of Decedent 10a. State 10b. County	v	10c Cit	y, Town or Lo	cation				1	0d. Inside City Limi			
6			1										
Director	MARYLAND WICO	MICO	5	SALISBU	10f. Zip Code			10g Citizen of V	What Cour	itry?			
	1505 LAVALE TE	PPACE			21804	4			VIII. 000				
Funeral	11. Merital Stefus	12. Was Dece	dent Ever in U	.S. 13. 1			n? (Specify Yes or N		a - Americ	an Indian,			
À	1 □ Never Merried 2 □ Me 3 ☑ Widowed 4 □ Divorce	Armed Formation 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2□No USI	MC	f Yes, specify Cul 1 ☐ Yes 2 ② No		Puerto Rican, etc.)		v				
Be Completed	15. Decede	nt'a Education est grade completed)	-11-11-11-	16a. Dece	dent's Usual Occu	upation e during most o	of working	16b. Kind of B	usiness/In	dustry			
hple	Elementary/Secondery (0-12)		4or 5+)	life.	DO NOT use retir	ed)							
Con	12			SUPER	VISOR			2. Dete of Deeth Month Per 2000 2 12 0 affon of Death Y WICOMICO 8. Date of Birth (Month, Dey, Year) JAN. 5, 1921 9. Birthplece (State or Foreign Country) JAN. 5, 1921 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? U.S.A. 21y Yes or No- Icidan, etc.) 14. Reca - American Indian, Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry NATIONAL CAN CORP. (First, Middle, Meiden Sumame) KRITCHEN Route Number, City or Town, Stete, Zip Code) 30N, MD 21204 Date 20c. Location - City or Town, State 20/9/00 HURLOCK, MARYLAND 705 E. MAIN ST. INC. SALISBURY, MD 21804 respiretory arrest, Approximate interval Between Onset and Death 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No					
Be	17. Father's Name (First, Middle								ne <i>)</i>				
70	JOHN H. WAGN					ANN							
	19a. Informant's Name/Relation			19b. Mailir	ng Address (Stree			ural Route Number, City or Town, Stete, Zip Code)					
	REBECCA STRAU	R	lent o		BELLONA sition (Name of	AVE.	1		Chart	um Cinto			
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (
	21. Signature of Funeral Service	705 E.	MAIN	ST.									
	Melissa	SALIS	BURY.	MD 2180									
	23a. Part1. Enfer the disease, o shock, or heart faiture. Lis	arrest,	i	Approximete									
Examiner	resulting in death) Sequentially list conditions,	1											
edicai Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last												
Be Completed by Physician/Me		d											
/sic	Part II. Other significant conditi	fons contributing to dea	ath but not res	ulting in the u	nderlying cause (given in Part I.	23b. Df	d tobacco use co	ontribute t	the cause of dea			
P.	renc	I tale	LE .				10	Yes 2 No	3 Pro	bably 4 Unkr			
by		0					04= 34/=	t i i i i i i i i i i i i i i i i i i i	24b W	ere autoney findin			
etec	Mu	ostati Ca	nces						av	ailable prior to impletion of cause			
Idu									3. Time of Dee 2000 2120 Inty of Death ICOMICO 9. Birthplece (State or Fore Country) PENNSYLVANI 10d. Inside City Lity 1 yes 25 In What Country? Interpretation (State or Fore Country) Interpretation				
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ation:	27. Manner of Death 1 Natural 5 Pend 2 Accident invest	0											
()	3 Suicide 6 Could deten	minad 200. Placa	28e. Placa of Injury - At home, farm, street, factory, offica determined determined building, etc. (Specify)										
Certifica			29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner (Check only one) Medical Examiner: On the basts of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end do and manner stated.										
edicai Certifica	(Check only 2 Medica	Examiner: On the ba	sls of examine										
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Medicai Certifica	(Check only 2 Medica one) 2 Medica 29b. Signeture and title of certifit	il Examiner: On the baland mannier GUL n who completed cause WEN RICK	sls of examine er stated. Much	m 23a) (Type,	29c. Lice	r opinion, deeth		e, date end plece,	, end due t	Day, Year)			

DHMH 16 Rev 6/95

Funera Directo

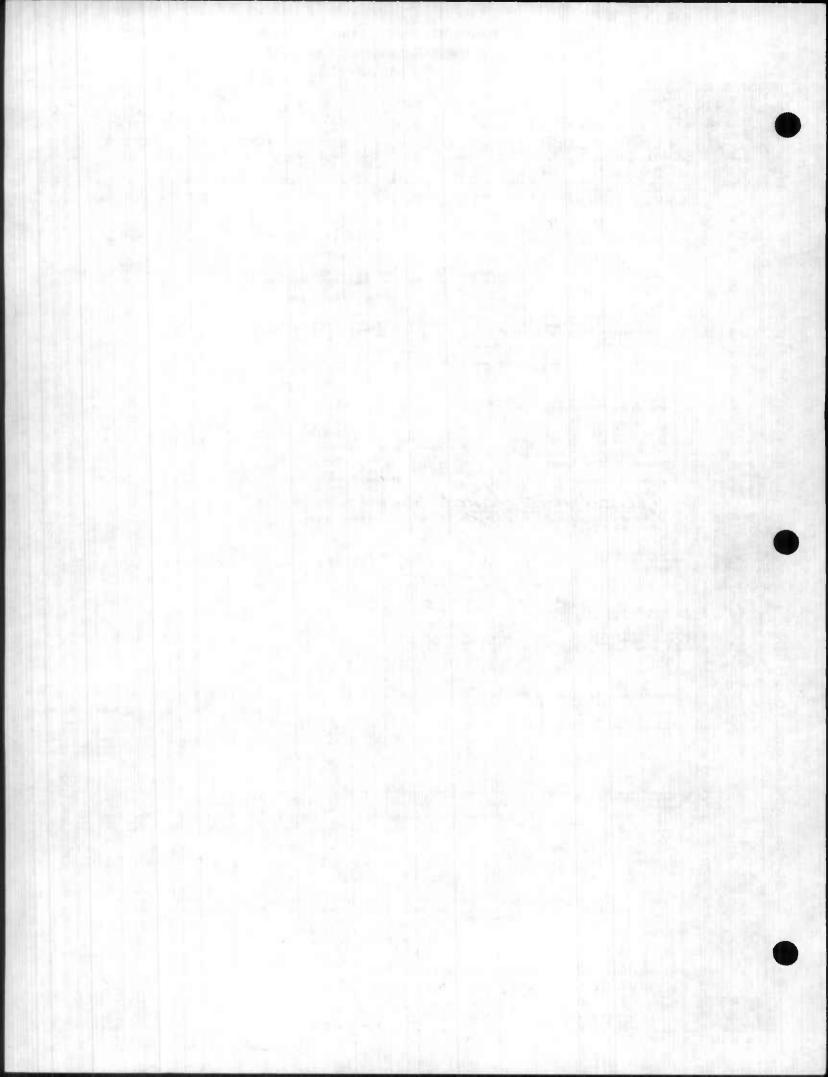
Physician /Medica Examine

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours effer deeth.

To the Funeral Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit

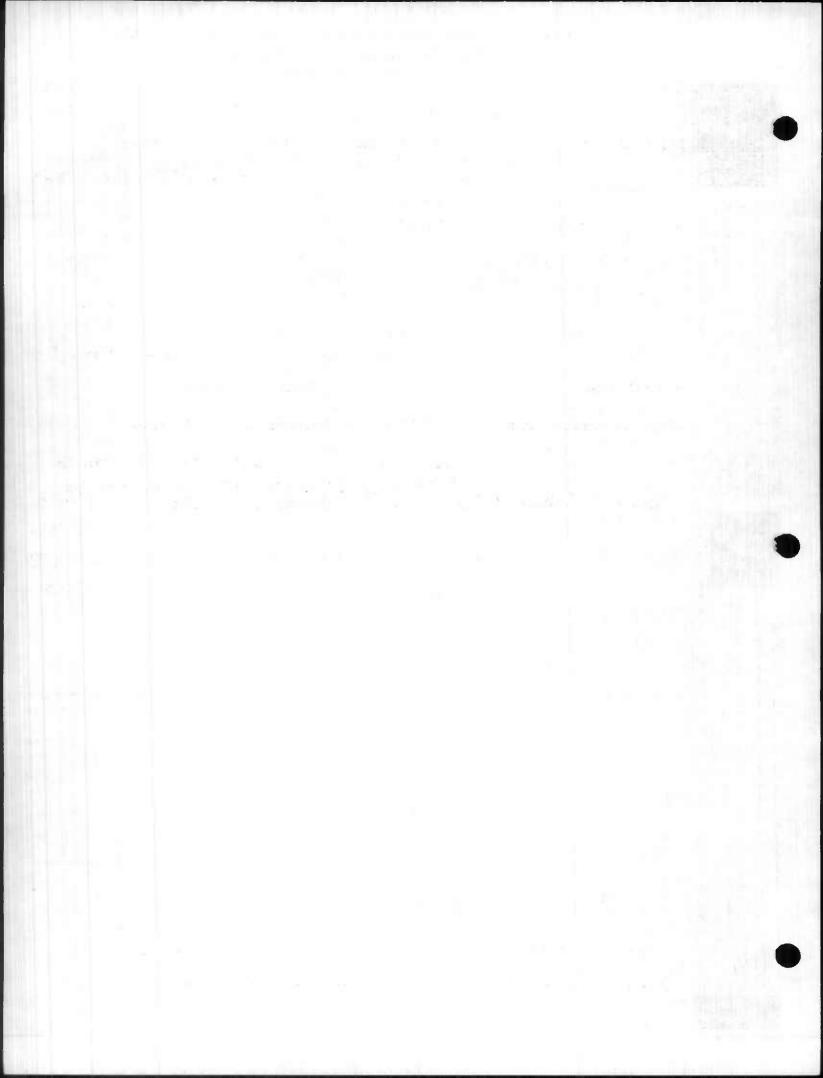
Division of Vital Records, P.O. Box 68760,

176052490



State of Maryland / Department of Health and Mental Hygiene

					Certifi	cale of	Death		Re	g. No.) 00	_ 0 0 0		
/sicia		Decedent's Name (First, Middle, Last)						Date of Deeth Month Day Yeer				3. Time of Dea		
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amine	-	4a. Fecility Neme (If not institution, giva street end number)					4b. City, Tow			4c. County	of Deeth			
		St. Agnes Nursing & Rehabilitation Center Ellicot												
al	1		Sex 7. A	ga (In yrs. las	Mo	Under 1 Year onths Days	If Under 2 Hours	Min.	Date of Birth Month, Dey,	of Birth h, Dey, Year) 9. Birthplaca (State or Foreign Country)				
r	-	178 01 8701		88	Yrs.			Se	pt. 6,	1912	Penn:	sylvani		
	-	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location								100	d. Inside City Li			
	0	140	3	0-	1							1 Yes 2X		
	Director	MD Howard Columbia 10e. Streef end Number 10f. Zip Code							10g. Citizen of Whet Country?					
							22044		10		35-05			
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	5	1 Never Married 2 Married	Armed Forces	Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Yaer or Dates:			nt of Hispenic Origin? (Specify Yas or N y Cuban, Mexican, Puerto Ricen, atc.)			Black, White, etc.				
	ò	3 XWidowed 4 □ Divorced	If Yes, Give				Specify:			Specify: white				
		15. Decedent's E	ducation		16a. Decedenf's	s Usuel Occup	pation		1	6b. Kind of Bu	usiness/indu	stry		
1	Completed	(Specify only highest gr Elementery/Secondary (0-12)	de completed) College (1-4or 5+)		(Giva kind of work done during most of wor life. DO NOT use retired)			of working						
	6	12	College (1-40)	5+)	Seamstress				D		ress Factory			
	Be C	17. Fether's Nema (First, Middle, Las	a (First, Middle, Last)				18. Mother	's Name (Fil	st, Middle, M	aiden Sumen	7e)			
- 3	0	Michael Crake					Helen unknow				wn			
		19a. Informent's Name/Relationship	Type, Print) 19b. Mailing Address (5			ddress (Street	end Number	r o <i>r Rurei R</i> o	ute Number,	er, City or Town, Stete, Zip Code)				
		Elaine Raksis/Dat	uahter		10618	Green M	ounta:	in Cir	cle Co	lumbia	, MD	21044		
		20a. Method of Disposition		000	ce of Disposition	n (Neme of	cel	D	ete 2	0c. Location -	City or Town	n, Stata		
		1X Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci)	Mary's	y or ourer pre	C 0)	10-4	-2000	Wilkes	-Barr	o DA		
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	+	220 Ports Fotor the disease or see	eno-N.	yee.	4112	2 Old (Columb:	ia Pik	e Elli	cott C		MD 2104		
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n al		Immediete Ceuse (Final		- 11.0		10111								
r	- 1	disease or condition resulting In death)	ө	e. CARDIAC ARAHYTHMIA 5 MWUTES Due to (or es e consequence of): NE MENTIA YEARS										
			Due to (or es e consequence of):									15115		
1		•	b											
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death Year Charles Elwood WARNICK Sept. 13, 2000 10:10 AM 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Garrett County Memorial Hospital 0akland If Under 1 Year | If Under 24 Hrs. | Garrett 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1₩ 2□ F Yrs. 217-20-5554 30,1925 West Virginia Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Garrett 0akland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18281 Garrett Highway 21550 USA Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedant Evar in U,S. Armed Forces? 11 Marital Status 1 Never Merried 2 Merried 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: White WW II 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 12+ Foreman Paper Production 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Henry Leonard Warnick Ressie -----Coakley 19e, Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Leota B. Warnick/Wife 18281 Garrett Hwy., Oakland, Md. 21550 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Deer Park Cemetery 9/16/00 Deer Park, Md. 21. Signeture of Funeral Service Licensee 22. Neme and Address of Fecility Stewart Funeral Home Dogow 32 S. Second St., Oakland, Md. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between Onset and Death Immediate Cause (Finel Cardiomyopathy Months disease or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Dua to (or as a consequence of): Dua to (or as e consequence of): 23b. Dfd tobacco use contribute to the cause of death? Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. Yes 2 No 3 Probably 4 Unknown emphysema 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes t □ Yes 2 □ No. 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 28e. Dete of tnjury (Month, Day Year) 28c. fnjury et Work? 28d. Describe how injury occurred 28b. Time of 1 Neturet 5 Pending 1 Yes 2 No investigation

Examiner The law requires that the death certificate be executed attending physician for use as the buna Box 68760. Physician/Medicai 60 deteched Division of Vital Records, P.O. s been signed by the should be detechþ Completed certificate To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; to Be Certification: To

Physician /Medical

Examiner

Physician

/Medical

Examiner

Funeral

Director

Items 23s or 28s-f show

Director

Funeral

þ

Completed

Be

permit. Peges 1 and 2 ahould be filed within 72 hours after death with the Maryle Department of Health and Maryla Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f ahow with Injury or other traumatic event, the Medical Examiner must be notified a pare.

Baltimore, Maryland 21215-0020

with the Maryland

Robert A. Goralski 31. Dete filed (Month, Dey, Year) State SEP 14 2000 Registrar

2 Accident

3 Suicide

29a. Certifier (Check only one)

Medical

4 Homicide

29b. Signature and little of

6 Could not be determined

32. Registrer's Signeture

30. Nemi and adverse of person who completed causa of deeth (ftem 23a) (Type, Print)

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

311 n. Fourth St., Oakland, Md. 21550

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

I Madini Pramfner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

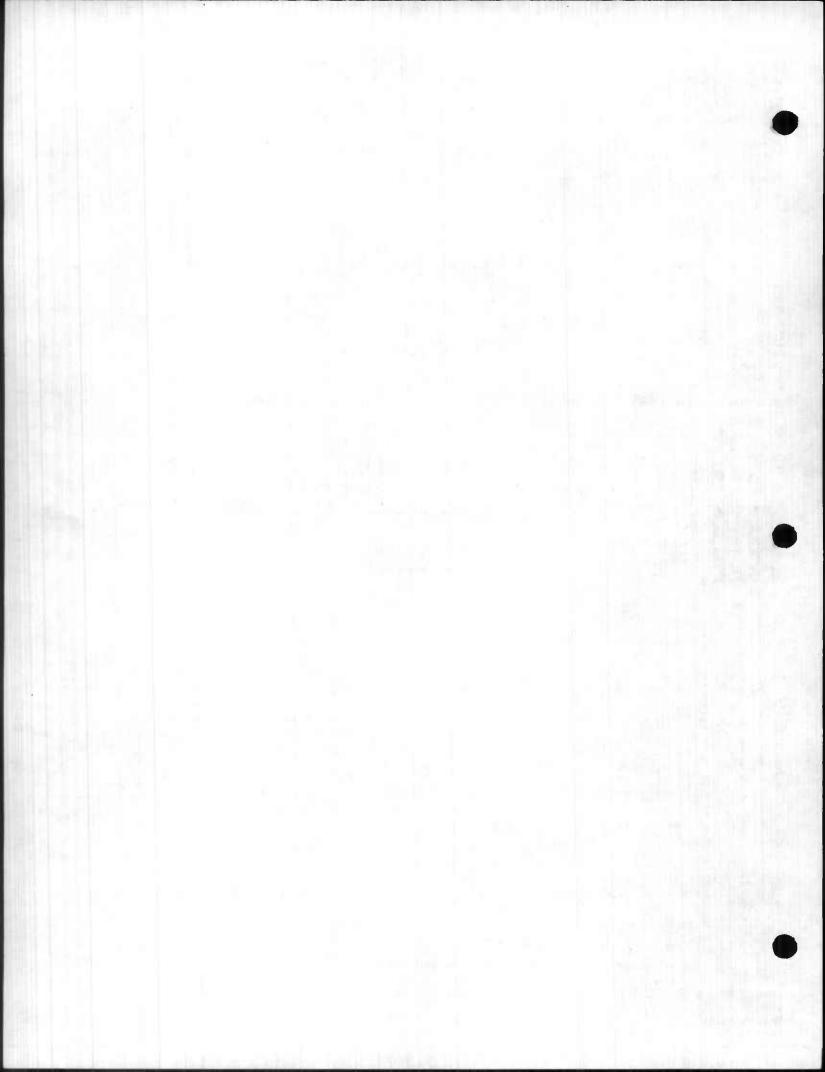
D23979

281, Location (Street and Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Day, Year)

9-14-00

DHMH 16 Rsv 6/95



		State of Ma	ryland		rtment <i>tificate</i>			d Mental Hy	/giene	0 3	2090		
	1. Decedent's Name (First, Middle, Last)								eeth	Yaar	3. Tima of Death		
Physician /Medical	Jin Yim								23, Day 2000) Talai	9:10am		
Examiner	4e Facility Neme (If not institution, give street end number)							or Location of Dee		4c. County of Death			
	2204 Bear Valley Terrace 5 Social Security Number 6 Sex 7 Ana (In vrs. lest hirthday) f Under 1 Ye						Silver Spring Montg						
Funeral Director	5. Sociel Security Number 6. Se 058-70-1303	st birthday) Yrs.		Deys		Vin. (Month, D	ey, Year)	9. Birthpla Country China	ca (Stete or Foreign y)				
pue 🛊	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location									100	d. Inside City Limits		
within 72 hours effer death with the Meryland ene. Nether 'netural', or fems 23s or 28s-f show the Medical Examiner must be notified at the Property of Funeral Director.	Maryland Montgome	ery Silver Spring				O'					1 ☐ Yes 2 ☑ No		
r flems 23s or 28s-fs spermant be notified Funeral Director	10e. Street and Number 10f. Zip C								10g. Citizen of	y?			
2 d d	2204 Bear Valley		20906					U	SA				
ma 2	11. Maritel Status	12. Was Decedent B	12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yas 2 ☑ No					? (Specify Yes or N		n Indien,			
by by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yas 2 ☒ N If Yes, Give				☐ Yes 2⊠ No Specify:			Specif	Black, White, etc. ecity: Asian			
t, the Macelland Completed	15. Decedent's Ed	15. Decedent's Education 16e. Decedent's Usual Oc (Specify only highast greds completed) (Give kind of work de					pation during most of	working	16b. KInd of Business/Industry				
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Be ver	Chee Lun Yim							ine Chi	e, maioen oumer	ira)			
To	19a. Informent's Name/Relationship (7	(vne. Print)		19b. Meilin	ng Address /	(Street			Noute Number, City or Town, Stata, Zip Code)				
27 le	Mattan Yim / Son										ing, MD 20906		
e de l'	20e. Method of Disposition		20b. Ple	ce of Dispos	sition (Nem	e of		Dete	20c. Location - City or Town, State				
A ST H	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	1 Burial 2 Cremation 3 Removel from Stata cemetery, cremetory or other place)						09/28/00	Silver	Spring	. Maryland		
Importal any Inju	21. Signature of Funeral Service Licen	Gate of Heaven Cemetery 09/28/00 Silver Spring, Maryland 1. Signature of F) haral Service Licensae 22. Name and Addrass of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904											
	23a. Part1. Enter the disease, or complications of ceused the death. Do not entar tha mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.								1 1	Approximete Intervel Between			
nysician		Shows, of fleate landie. List only one cause of each line.									Onset and Death		
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	resulting in death)		Due to (or	es e conseq	juence of):								
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d for	Pert II. Other significant conditions of	Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse givan in						art I. 23b. Did tobacco use cor			ntributa to the causs of death?		
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be de de Dy P													
should should been si									24a. Wes an autopsy performed? 24b. Were eu available				
pe 2 sh										of de	opletion of cause eath?		
cate has been significant.								10	Yes 2 GNo	10	Yes 2□ No		
certificate rector, pa	25. Wes case referred to medical examiner?	26. Plece of Death (Check only one)											
this ce al dire	1 ☐ Yes 2⊠ No	Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other				4 LI NUISI	4D Milishing House SCXVesidence o Chomes						
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within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated. 29a. Certifier (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s)										ited. the ceuse(s)		
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3	win) nã.		2015			5 5052457 Sep						
	30. Neme and address of person who o	completed cause of de	eath (Item 2	23e) (Type.	Print)								

DHMH 16 Rev 6/95

State

Registrar

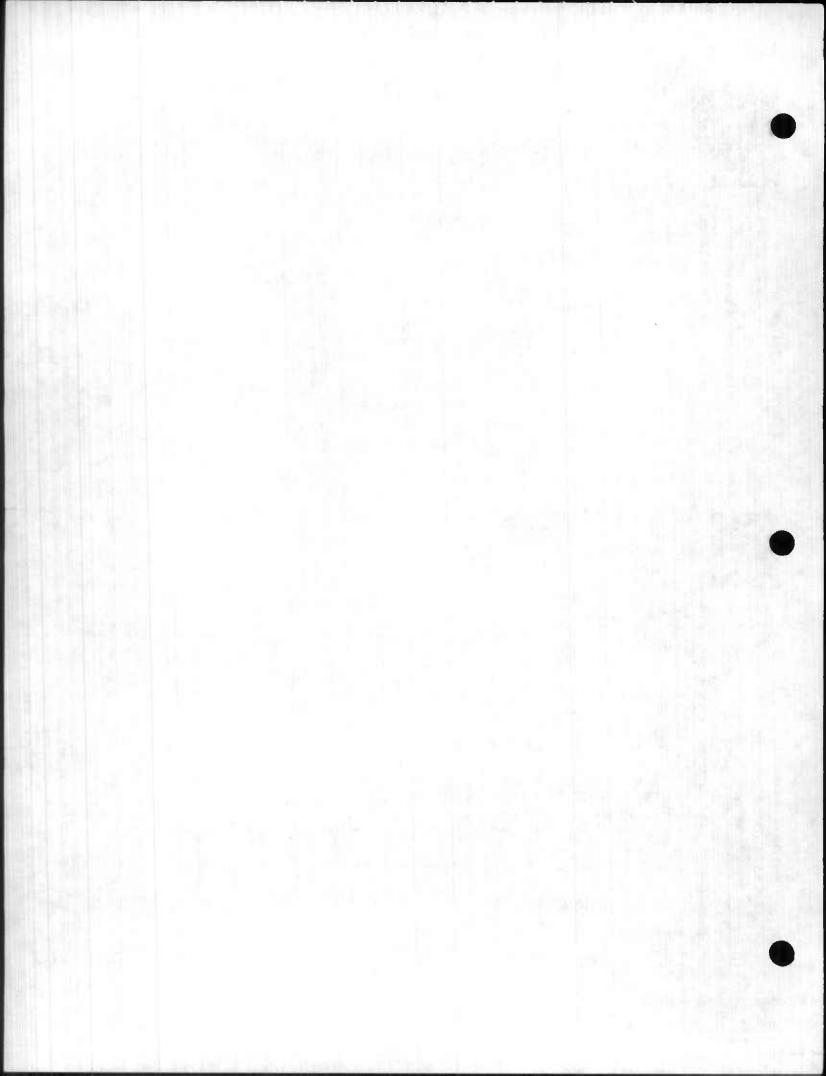
Mo Chow, M.D. 31. Date filed (Month, Day, Year)

SEP 2 7 2000

32. Registrer's Signeture

9001 Shady Grove Court, Gaithersburg, Maryland 20878

souls



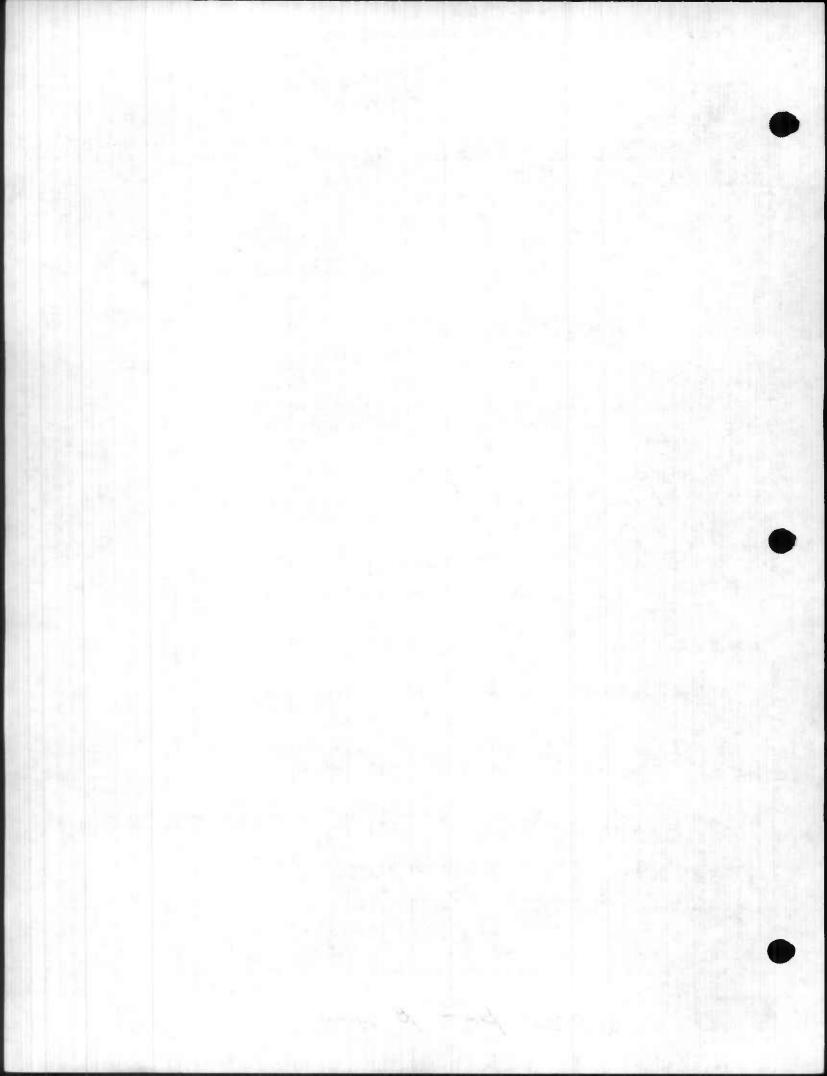
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** GLADYS EALER YOUNG 25 2202 Sept 2000 /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Memorial Hospital Easton Talbot If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 M 2 XF Months Days Hours 83 Yrs. 219-82-0906 Director PA Usual Residence of Decedent r 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Young 1 ☐ Yes 2 ☐ No Director MD TALBOT ST. MICHAELS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? them 27 is marked other than "natural", or flams 23s or other treumstic event, the Mildical Examiner must be r 402 WATER ST. 21663 USA Funeral Gladys Baltimore, Maryland 21215-0020 11. Marital Stetus 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or 1 Yes 2 No Specify: WHITE þ 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementery/Secondery (0-12) Coltege (1-4or 5+) OWNER/OPERATOR 11 0 RESTAURANT 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be fill Department of Health and Mental Himportant: If hem 27 is marked other by Injury or other treumatic even Be EUGENE NICHOLAS LYDIA EALER 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON YOUNG/ DAUGHTER PO BOX 96 ST. MICHAELS, MD 21663 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donation 5 □ Other (Specify) 9-29-00 OXFORD CEMETERY OXFORD, MD 22. Name and Address of Fecility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner shon Examiner ettending physicien and for use as the burial-trens Sequentiatly list conditions, if eny, teading to immediate cause. Enter Underlying Cause (Disease or trijury that hitiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by 1 Yes 2 No 3 Probably 4 Onknown Dys tune tous by 24a. Was an autopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of death? Completed page 2 s certificate hes 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No st or Attending Physics after death.
I Director: After this ce 1 Inpatient 2 EB Outpatient 3□ DOA 10 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 \ Homicide To the Hospital within 24 hours a To the Funeral C Hospitat Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) Statt Phosicing 29c. License number 29b. Signature end title of codi D50325 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) JAMES F. ELMORE, M.D. 219 S. WASHINGTON ST EASTON MD 21601 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State souls

DHMH 16 Rev 6/95

Registrar

SEP 2 7 2000



State of Maryland / Department of Health and Mental Hygiene

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by Funeral Director	11. Maritat Status 1 ☐ Never Marrie 3 ☐ Widowed 4		12. Was Deced Armed For 1 🗍 Yas : If Yes, Give Yaar or Da	cas? 2√2 No			edent of Hi ecify Cube 2 No	spanic Origin n, Mexican, F Specify:	? (Specifi Puerto Ric	y Yas or No- an, atc.)	14. Ra Bl Spec	ice - Amari ack, White,		
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Physician/Medical Examiner	Sequantially list con- if any, laading to imn- causa. Entar Undarl Cause (Disaasa or in thet initieted events resulting in death) Le	ying ijury		Dua to (c	RENAL or as a consec EROTIC or as a consec or as a consec	CARI): D IOVA!):		HEAL	RT DIS	EASE			NTHS
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<u>a</u>		Certifying Ph	niner: On the bas	sis of examina										usa(s)
op o	end mennar steted. 29b. Signature end title of certifier 29c. Licansa number							number			29d. Data sign	ned (Month	, Day, Ye	ar)
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aminer		se. Fecility Neme (If not institution, git 13711 JOHN CLINE		per)				4b. City, Town, o	r Location of Dee	th 4c. Cour	nty of Death	N
eral ctor			Sex 7. 1□ M 2√ F	Age (In yrs.	lest birthday) Yrs.	If Under 1 Months D	Yeer	If Under 24 H. Hours Mi	n. (Month, D			piece (Stete or Foreigntry)
	-	Usuel Residence of Decedent		40.0					DEC 2	7_1906_		RYLAND
or or		MARYLAND WASHIN	CTON		ty, Town or Lo						ľ	1 ☐ Yes 2 ☐ N
Director		10e. Street end Number	GION	Ollx	THODOR	10f. Zip Co	ode			10g. Citizen o	of Whet Cou	
rai D		13711 JOHN CLINE	ROAD			2178	3			U	.S.A.	
by Funeral		11. Meritel Stetus 1 Never Merried 2 Married 3 Nover Merried 2 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Yeer or Dete	es? No	1	Wes Deceden f Yes, specify I ☐ Yes 2.	Cube	fispenic Origin? en, Mexicen, Pue Specify:	(Specify Yes or N arto Ricen, etc.)	В	lece - Americ leck, White, cify: WH]	etc.
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any injury or other traumand ance.		DARYL ZEMBOWER		SON				REEK ROA		ORD PA.	1552	
	2	20e. Method of Disposition			Plece of Dispo cemetery, cren	sition (Name netory or othe	of or plea	ce)	Dete	20c. Locatio	n - City or T	own, State
SUC#	-	4 ☐ Donetion 5 ☐ Other (Speci 21. Signeture of Funeral Service Lige		PLI		GROVE			SEPT 22	2000 CU	WREKLY	AND MD.
SUCE		71.41	int		ME	RRITT-	AD.	AMS FUNI	ERAL HOM			
	+	23a. Pert1. Enter the disease, or conshock, or heert feilure. List only	pplications that cau	sed the deel	th. Do not enti	4 DECA er the mode o	TU of dyin	R STREET ng, such es cerd	CUMBER ec or respiretory	LAND MA errest,	RYLANI	Approximete Intervei Between
an	1											Onset end Deeth
cal ner	- 0	Immediete Ceuse (Finel diseese or condition resulting In deeth)	e				И	CART	FAIL	-VRE	1	YEARS
e e			~		or es e conseq		6	CLENCY				YEARC
Examiner		Sequentially list conditions,	b		or es e conseq			0.4001			1	1011
E E	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury c.											
edical Examir	, ,	thet initieted events resulting in deeth) Lest				į						
Physician/M			d								i	
sici	F	Pert II. Other significant conditions	contributing to deat	h but not res	uiting in the ur	nderlying caus	se giv	en in Pert i.	23b. Die	tobacco use	contributs t	o the cause of death
y Ph									1 [Y98 20 No	3 ☐ Pro	bably 4 Unknow
ed by Physician/Me									24e. We	s en eutopsy formed?	24b. W	ere autopsy findings eileble prior to
Completed	-								- per	ioimed?	CC	empletion of ceuse deeth?
To Be Com									1□	Yes No	1	☐Yes 2☐No
Be		25. Wes case referred to medical exeminer?	Hospitel:				Oth	or:	eeth (Check only			
et		1 Yes 2 No 27. Manner of Death	28a, Dete of (Month,		ER/Outpatien 28b. Time of		Injur Wor	4 Li Nursing		how injury occ		fy)
atio		1 Naturel 5 Pending investigation	ก	Dey Year)	Injury	М		Yes 2□No				
		3 ☐ Sulcide 8 ☐ Could not be determined	200. PIECE OF	tnjury - At h , etc. (Specia	ome, ferm, str	eet, factory, o	ffice			(Street and Nu own, State)	m <i>ber</i> or Run	al Route Number,
artin		29e. Certifier 15 Certifying PI	nysician: To the be miner: On the basi	s of examine	wiedge, deeth	occurred et t	the tin	me, dete end ple plnion, deeth oc	ce, and due to the	e cause(s) end , dete and plec	menner es s	steted. the cause(s)
dical Certific	1	onel	end menne	Steted.		29c. L	icens	e number		29d. Dete sig	ned (Month,	Day Year)
Medical Certification:	2	one) 29b. Signeture end title of certifier		//								
Medical Certifi	2	one)	Ya	lia	MD	DI	20	097		9/8	20/00)
Completely filled in by the Medical Certification		29b. Signeture end title of certifier	completed cause	of deeth (Iter	m 23a) (Type,	Di	20	97		9/8	20/00	

1034 9

10:-

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day 3 Month **Physician** 1810 FRANK ABRAMOUKCZY 2000 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNES MORE HEALTH ALTI If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Jan 20, 1914 5. Social Security Number (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** 1⊠M 2□F Days Polland 86 214-16-6987 Yrs. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Madical Examinar must be notified at MD Baltimore Catonsville 1 Yes 2 No Director 10e. Streef and Number 10f. Zip Code 10g. Citizen of Whet Counfry? 21228 USA 55 Wade Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marifal Stafus filed within 72 hours after 1 Never Married 2 Married white Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry el Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) disabled none permit. Pages 1 and 2 should be file Department of Heelth end Mentel Hy Important: If flem 27 is marked other any Injury or other traumatic event bace. 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Vincent Abrams Anna Souvers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 900 S. Caton Avenue St. Agnes Hospital Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) in state 21. Signature of Euneral Service Lordina Wade, Director 22 Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Krace Baltimore, MD 21201 Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical DAYS ENCEPHA LO PATHY ANOXIC Examiner Due to (or as a consequence of). Physician/Medical Examine physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequanca of) Dua to (or as a consequence of): NAME ABRAMS, FRANK Division of Vital Records, P.O. Box Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to complation of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 1 Yes 28 No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certification of the funeral director: After the funeral director, it is a funeral director. 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: 1 tnpatient 2 ER/Outpatlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Menner of Death
1 Natural
2 Accident 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 ☐ Yas 2 ☐ No 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of cartifier OCTOBER 03 2000 P13604 MEDICAL KESIDENT who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 21229 RICHARD 900 CATON AVENUE ADDO, OFF

Registrar

State

31. Date filed (Month, Day, Year)

OCT 1 2 2000

32. Registrar's Signature

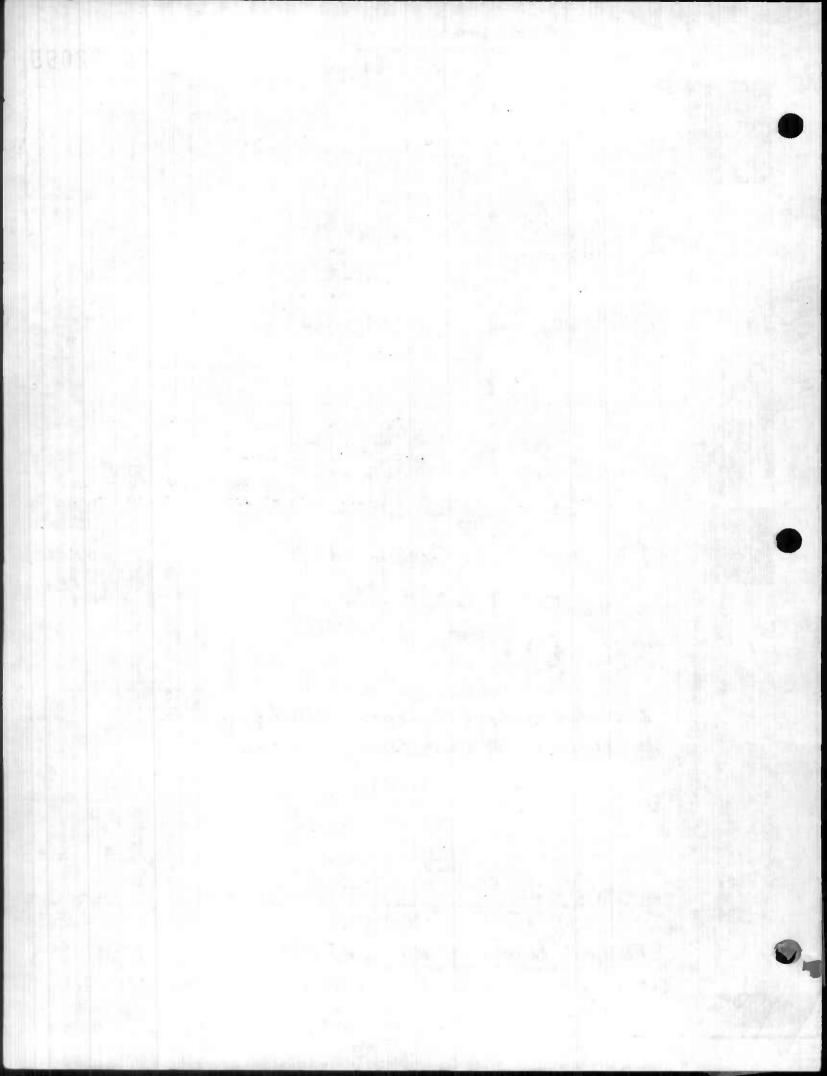
MANNE

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 32095 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month Year Physician 06, Allen H. Ashby Oct 2000 2:00am /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Elder Care Homewood Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days Hours Months 75 Yrs. 214-20-7655 04-17-25 Director MD Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 ie marked other than "natural", or itema 23a or 28a-f ahow traumatic event, the Madical Examiner man be notified at 1 Yes 2 No MD NA Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2707 Kirk Avenue 21218 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specity Specify: p 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiena. Important: if fiem 27 is marked other than 'na eny injury or other traumatic event, the Mental Page. Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Laborer Dupont company 18. Mother's Name (First, Middle, Maiden Surname) 17. Falher's Name (First, Middle, Last) Be Allen Ashby Estelle Ashby 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2707 Kirk Avenue Baltimore, Maryland 21218 Bernice Ashby Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
Donation 5 Other (Specify) Arbutus Mem. Pk. Cem. 10-11-2000 Arbutus, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 noculat WM.C.March FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner N certificata be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last pue Due to (or as a consequence of) burial-tran attending physician Due to (or as e consequence of) the usa as Por Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. ed by the a 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably A ☐ Unknown þ 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen The law r has 20 No I director, page 2 No 1 Yes of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this the funeral 27. Menner of Death 1 Detural 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attanding 5 Pending investigation To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 Tyes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3007 9 Northern Galtonne Parlmay 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State OCT 1 2 2000 Registrar

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amended Item#17 perFHG788 101/18/2000 ExState of Maryland / Department of Health and Mental Hygiene 32096 Amended Item#20b perFHG788 10/12/2000 EW Certificate of Death It's Name (First Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 2:12am /Medical 4b. City, Town, or Name (If not institution, giva street end number) 4c. County of Deeth Examiner mercu If Under 1 Yaar 5. Sociel Security 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dev. Yaer) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 F 031-16-2707 75 Yrs. Director 29 Mass. Usuel Residence of Dacedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 No Yes 2 No Md. n/a Baltimore Directo 10a, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Herna 23a 1530 Riverside Ave. 21230 USA Funeral 72 hours after death 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married natural, or Baltimore, Maryiand 21215-0020 1 ☐ Yes 2 No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede complated) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within than Elementery/Secondery (0-12) College (1-4or 5+) al Hygiene. Housewife Home Owner 9 0 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middla, Last) Be f Heelth and Mental Wright A. Edmondson Edmundson Mary F. McKenna 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1530 Riverside Ave. Baltimore, MD. 21230 of Disposition (Nama of Data 20c. Location - City or Town, Stete Francis L. Bory (Husband) 12 Data 20b. Plece of Disposition (Nama of cemetery, cremetory or other plece) 20e. Method of Disposition Department of H Important: If Ital any injury or oti pace. 1 ☐ Buriel 2 【Crametion 3 ☐ Ramoval from State Green Mount Cemetery 10/11/2000 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica License 22. Neme end Address of Fecility McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230 t1. Enter the disease, or complications that ook, or heart failure. List only one cause on Approximete Intervel Between Onset end Deeth sed the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** mmediata Ceuse (Finel disease or condition resulting in deeth) **IMedical** Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequantielly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated evants rasulting in deeth) Lest Due to (or es e consequenca of). Records, P.O. Box 68760, ettending physicien for use as the buris Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 2 24b. Were autopsy findings evailable prior to completion of causa of death? 24a. Was an eutopsy performed? Completed 2 1000 1 Yes 2000 1 Yes Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Depatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deeth 1 Naturel Injury et Work? 28d. Describe how injury occurred After 5 Pending invastigation after death.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 281. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 ☐ Homicide within 24 hours aft To the Funeral Dir completely filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the ceuse(s) and menner stated. 29e. Certifier Medical

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State Registrar

31. Dete filed (Month, Dey, Year)

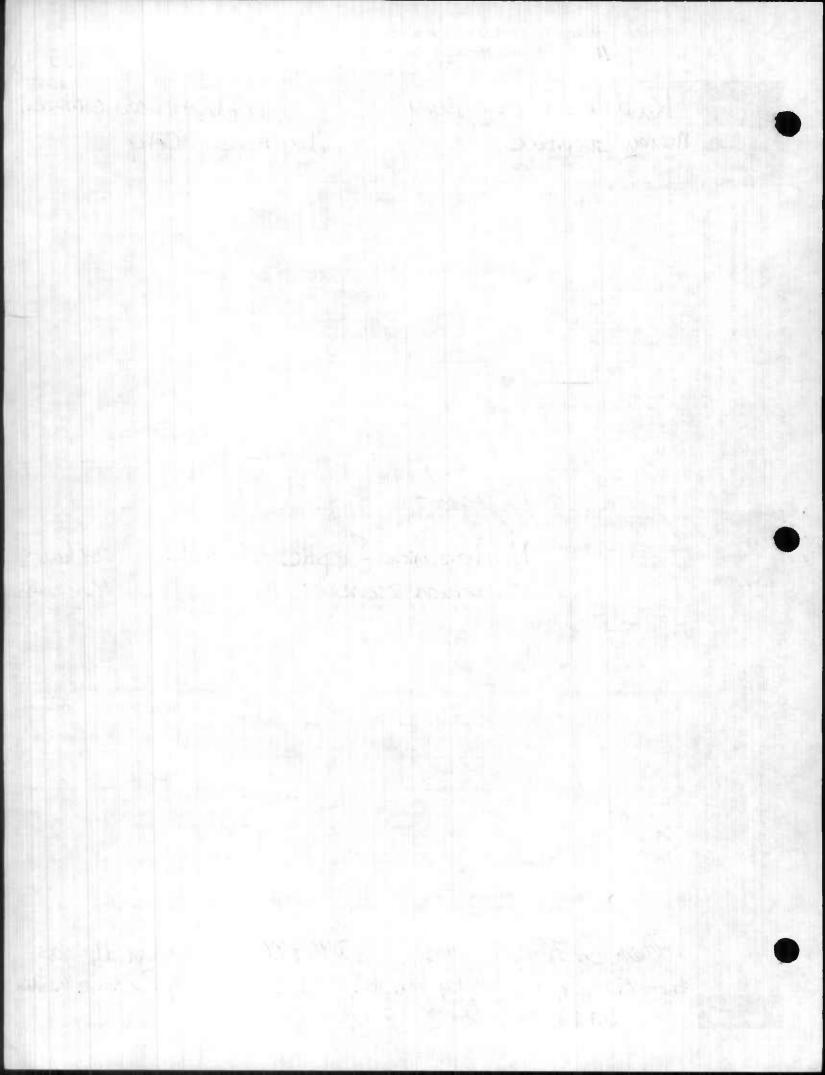
29b. Signature and title of cert

ith (Itam 23a) (Type, Print)

29c. License number

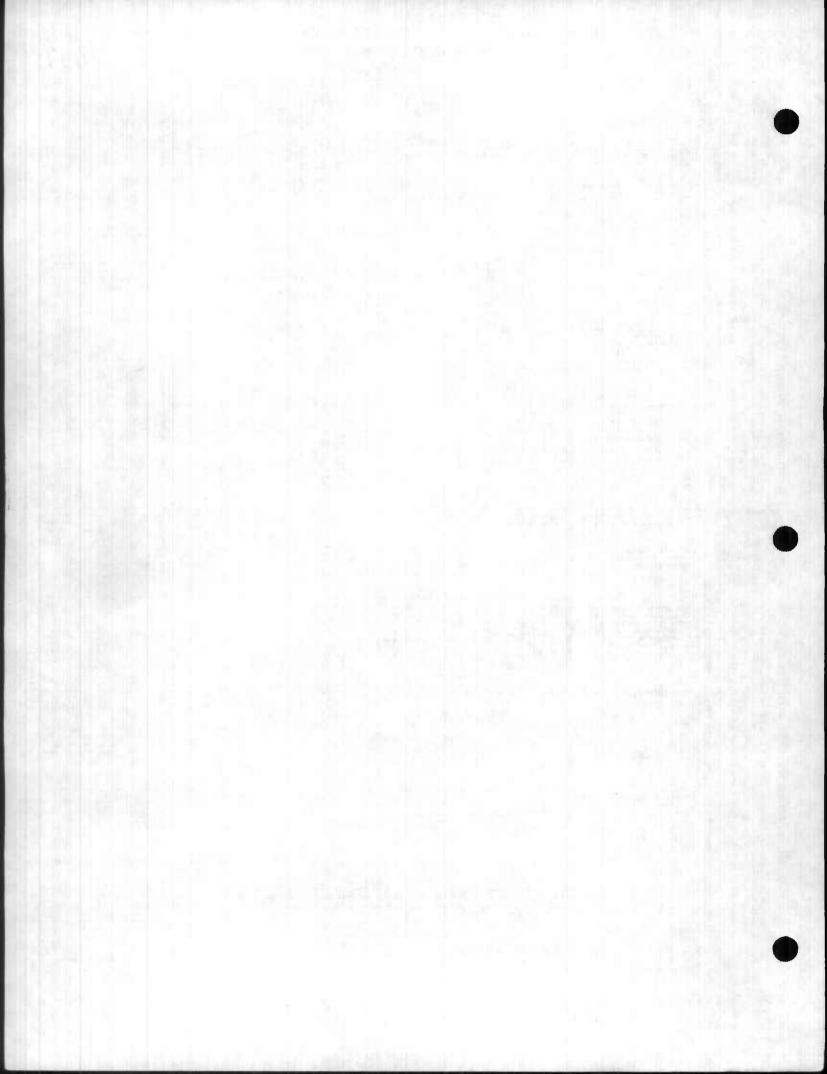
29d, Date signed (Month, Dav. Year)

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 00 32097

			Cert	tificate of L	Death		Re	g. No.	02001
Physic /Medi		1. Decedent's Name (First, Middle, Last) EUGENE	BL	-UHJ	1	2	Date of Death Month	Pay	Year 6 45PN
Exami		4a Facility Name (If not institution, give street and number) BON Secous Boulo	flea	Stary		Bal	tion of Death	4c. County Bac	
Funeral Director		5. Social Security Number 6. Sex 7. Age (in yrs. last 7. Age (in yrs. la	t birthday) Yrs.	Months Deys	If Under 2 Hours	Min. A	Date of Birth (Month, Dey, Apr 8,	Y921	Birthplace (State or Foreign Country) MD
e Maryland le-f show diled at	ctor	10a. State 10b. County 10c. City, T	Town or Local						10d. Inside City Limits 1 Yes 2 □ No
ter death with the Marylas Herre 23a or 28a-f show Inst. must be notified at	rai Director	10e. Street and Number 2095 Rockrose Avenue		10f. Zip Code	21	211	10	Og. Citizen of V	Vhat Country? SA
O # FE	by Funeral	11. Mental Stetus 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No		in? (Speci Puerto Ri	fy Yes or No- can, etc.)		e - American Indian, xk, White, etc. r: white
72 hours	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupi	funna most	of working		16b. Kind of Bu	usiness/Industry unk
within the Me	dwo	Elementary/Secondary (0-12) College (1-4or 5+)		teelworke					
Maryland 2 d 2 should be filed th and Mental Hygi 7 is merked other traumatic event, 1	To Be C	17. Father's Name (First, Middle, Last) unk			18. Mother	's Name (First, Middle, M	fa <i>id</i> en Surnem	e) unk
Agary 2 sho and h				g Address (Street					
C 25 W L				W. Baltin	nore S	Stree			MD 21223 City or Town, State
altimore, mit. Pages 1 a partment of Hes portant: if them y injury or othe cs.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🛱 Other (Specify) in State	etery, crem	etory or other plac			Date	EOC. LOCATION	Oily of Town, State
Balt permit. Depart Import any inj		21. Signature of Funeral Service Licensee Ronald S. Wade, Director	S B	Name and Address tate Anatal	omy I	30ard 2120	1		imore Street
		23 Part1. Enter the disease, or complications that caused the deeth. I nock, or heart feilure. List only one cause on each line.	Do not ente	r the mode of dyin	g, such es d	cardiac or	respiratory erre	est,	Approximate Interval Between Onset and Death
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. SLPS	15					145	
	ner	Dud to (or as	s a consequ	uence of):					1
58760, icate be executed physicien and s the burial-trensit	Examiner	Sequentially list conditions, Due to (or as	s a consequ	uence of):					
60, be exe	a E	Sequentially list conditions, if any, leading to immediate ceuse. Einter Underlying Ceuse (Diseese or injury that initiated events Due to (or as or course) C							1
The Paris	Medical	resulting in death) Lest Due to (or as	a consequ	ience of):					
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that the do	Physician/	Pert II. Other significant conditions contributing to death but not resulting to death but not resulti	ig in the un	denying ceuse giv	en in Part I.			e 2 No	ntribute to the cause of death? 3 DProbably 4 □ Unknow
cords	Completed by	8000					24e. Wes a perform		24b. Were autopsy findings available prior to completion of ceuse of death?
The lew ate hes b page 2 s	mo						1 □ Ye	s bono	1 ☐ Yes 2 ☐ No
Vital I	Be C	25. Was case referred to medical examiner?			26. Plece	of Death (Check only on	e)	
of Vita Physician: this certific	5	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER		3 DOA Oth	4 LI NU	-	e 5 Reside		
Ing Ing	Certification:	1 Maturel 5 Pending (Month, Day Year) 2 Accident Investigation	3b. Time of Injury		γat k? Yes 2□!	No	3d. Describe ho		
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the it	Certifi	4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)), farm, stre	eet, factory, office		28	City or Town		per or Rural Route Number,
To the Hospital within 24 hours a To the Funeral completely filled	edicai	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowle check only one) Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tin estigation, in my o	ne, date and pinlon, deat	d place, an h occurred	d due to the ca d at the time, d	use(s) and me ete and place,	anner as stated. and due to the cause(s)
To the Ho within 24 I To the Fu	Me	29b. Signature and title of certifier		29c. Licens	e number		2	9d. Date signe	d (Month, Dey, Year)
		I shall wolld		03	674	8		10/7/	00
		30. Name and eddress of person who completed ceuse of death (Item 23	a) (Typa, F	Falls (1000	e B	alto	MD	00
St	ate	31. Dete filed (Month, Day, Year) 32. Registrar's Signatur	B North	B 1	parks				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32098 Certificate of Death 2. Date of Deeth 3. Time of Deeth 1. Decedent's Nama (First, Middle, Last) 7.15 AM 2000 Mildred J. Bates OCTOBER 4e Facitity Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Yaar Birthplece (State or Foraign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Min. 1□M 2MF Deys Hours 235-40-3138 Yrs. 73 12-17-1926 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stata 10b. County 1 ☐ Yes 2 No MD. Anne Arundel Glen Burnie 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 7656 3Rd. Ave. U.S.A. Hace - American Indian, 21060 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yaar or Detes: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highast grede complated) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Housewife 17. Fathar's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Marvin Lane Nettie Goldsmith 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Doris Bates (Daughter) 5284 Randolph Rd. #146 Rockville, MD. 20852-2116 20b. Plece of Disposition (Neme of cematary, cremetory or other place) 20c. Location - City or Town, Stete 20e. Mathod of Disposition Data 1 ■ Buriel 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 10-12-00 Glen Burnie, MD. 21. Signatura of Funeral Service Licens 22. Name end Address of Fecility McCully-Polyniak Funeral Home P.A. 23a. Part Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiec or respiratory errest, Approximate intervet Between Onset end Death Immediate Ceuse (Finet disease or condition resulting in death) NEUMONIA Due to (or es e consequence of): WNG DISEASE CHRONIC OBSTRUCTIVE Sequentially list conditions, if eny, leading to immadiata cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Due to (or as e consequance of) 23b. Did tobecco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat 26. Plece of Deeth (Check only one) Hospitat: Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) 1□ Yes 2□ No 1☐Inpatient 2☐ ER/Outpatient 3☐ DOA 28b. Time of 28d. Describe how triury occurred 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident

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29a. Certifier

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29b. Signature and the of cootie

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32. Registrar's Signeture

MI

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

NORTH ARUNDEL HOSPITAL- GLEN BURNIE- MD 21060 20cks

tize criffying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and plece, end due to the cause(s) and menner stated.

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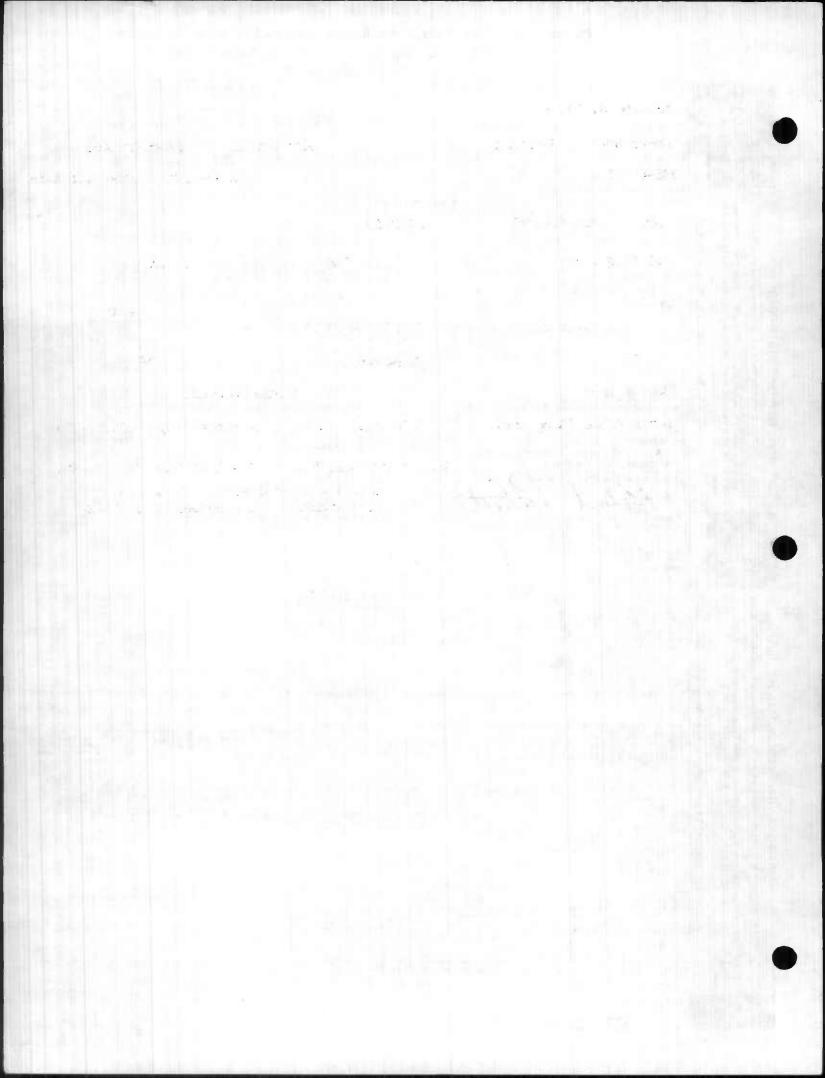
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29d. Date signed (Month, Dev. Year)

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Location (Street end Number or Rural Route Number, City or Town, State)



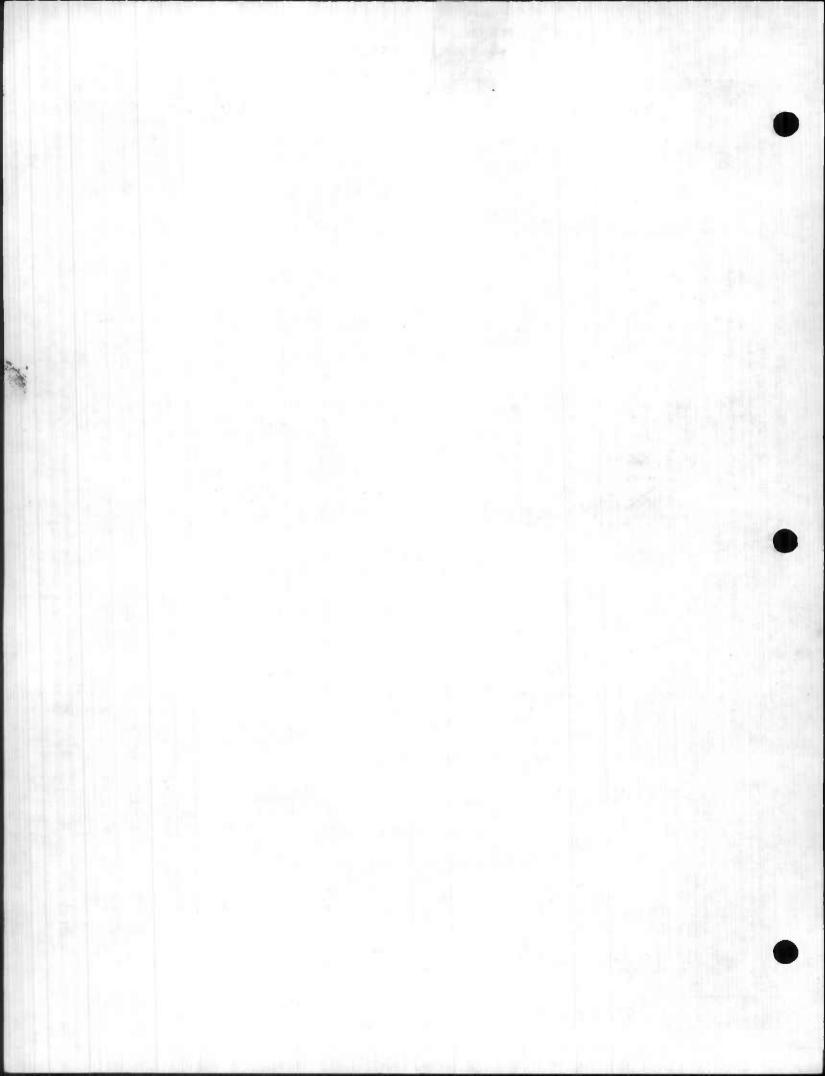
State of Maryland / Department of Health and Mental Hygiene 321199 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** E. BROHAWN HELEN 09 12:08 AM 00 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hill Haven Nursing Home Prince Georges' Adelphi 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 82 Yrs. 218-05-9682 October 20,1917 Maryland Director Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 N Yes 2 No Directo Baltimore Maryland Baltimore must be notifi-10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ð 524 North Charles Street 21201 23a United States 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Race - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hyglene.

ant if itsen 27 is marked other than "natural", or itse ury or other traumatic event, the Medical Examins 1₺ Never Merried 2 Married 21215-0020 1 Yes 2₺ No Specify: Specify: White Aq 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shift Supervisor Communications 12 Saltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 89 Myrtle Dames Irving Brohawn 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 18230 Fox Chase Circle, Olney, Maryland 20832 Carol Brohawn/Niece 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete ¥□¥urial 2□Cremetion 3□Removel from State Department o Important: If any Injury or Loudon Park Cemetery 10-1-00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Furjerel Service Licenses 22. Name end Address of Fecility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229 is the death. Do not enter the mode of dying, such as cardiac or respiratory errest, 23e. Pert1. Enter the diseese, or complications of shock, or heart feilure. List only one cause Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Examiner The law requires that the death certificate be executed the burial-tran Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in deeth) Last Due to (or es e consequence of): Box 68760, physician Completed by Physician/Medical Due to (or es e consequence of): for use Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? brova scular accident 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 2000 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Wes case referred to medical examiner?
1 Yes 2 No Be 26. Piece of Deeth (Check only one) Other: Warsing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Date of Injury (Month, Day Year) Manner of Deet 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of After Netural 5 Pending 1 Yes 2 No death. Investigation 2 Accident To the Hospital or Attenditude within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Medicai 29e. Certifie 1 Scrtifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner es stated. (Check poly one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 11251 Lockwood Drive, Silver Spring, Maryland 20901 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State OCT 1 2 2000

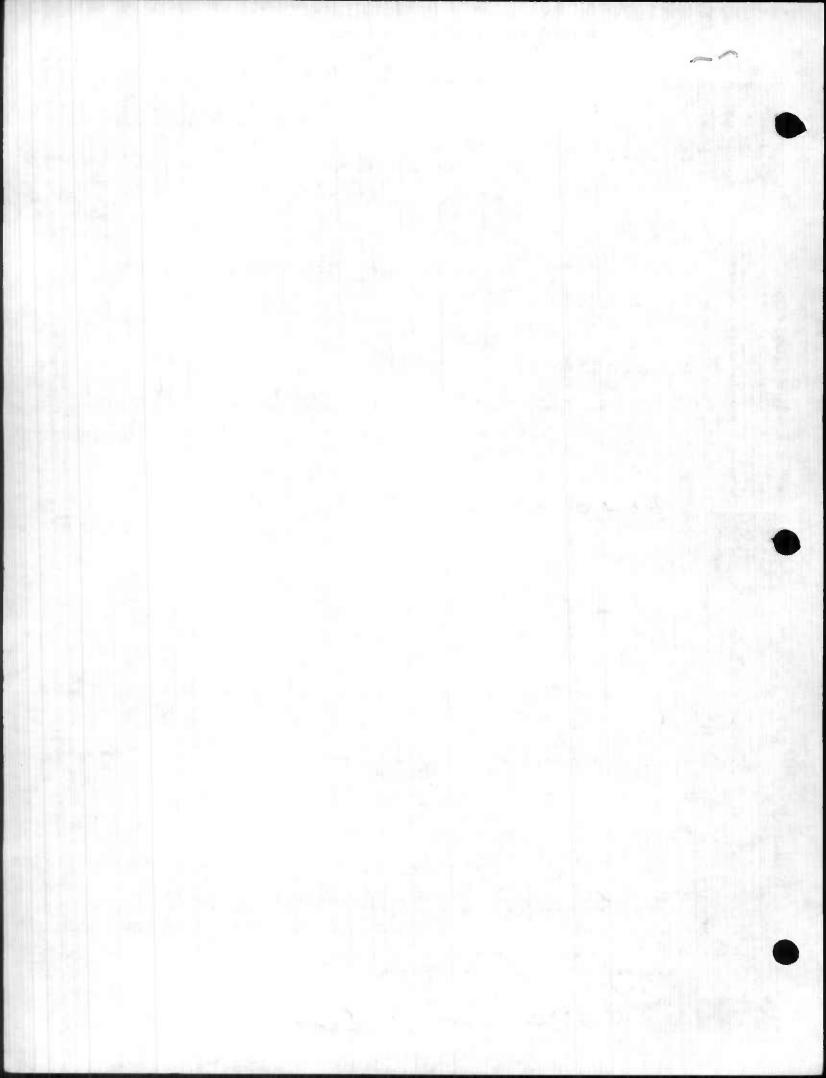
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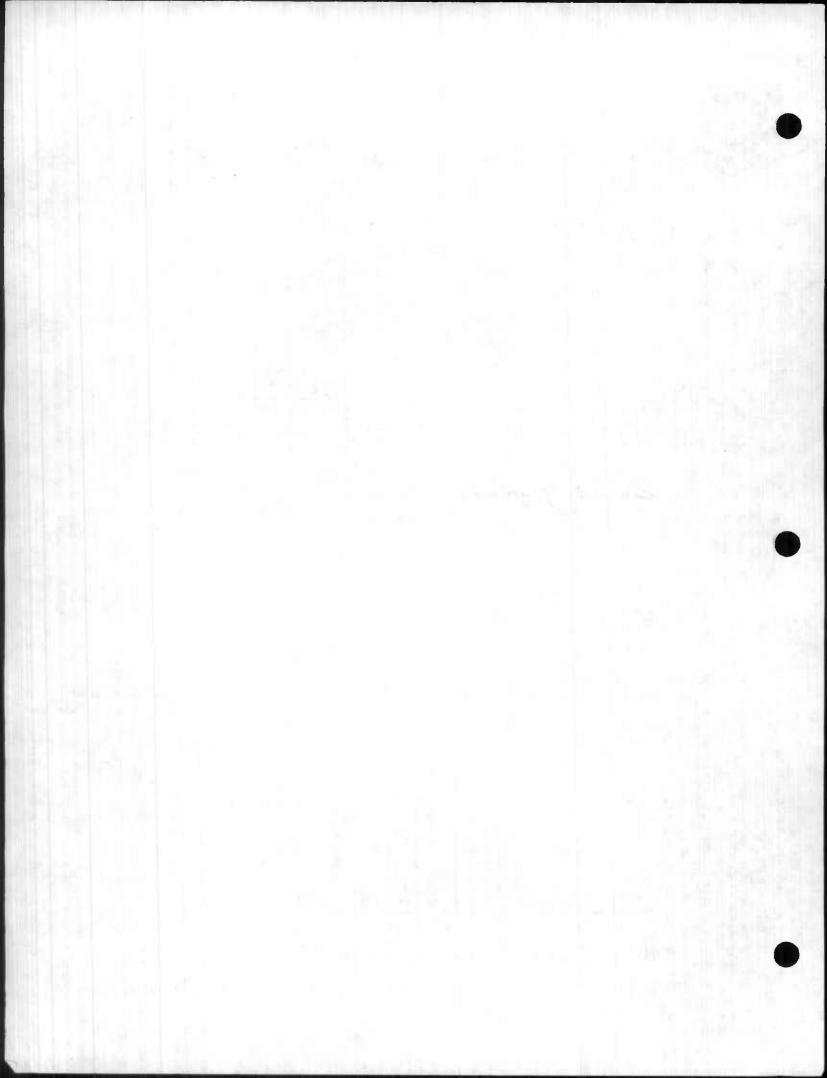
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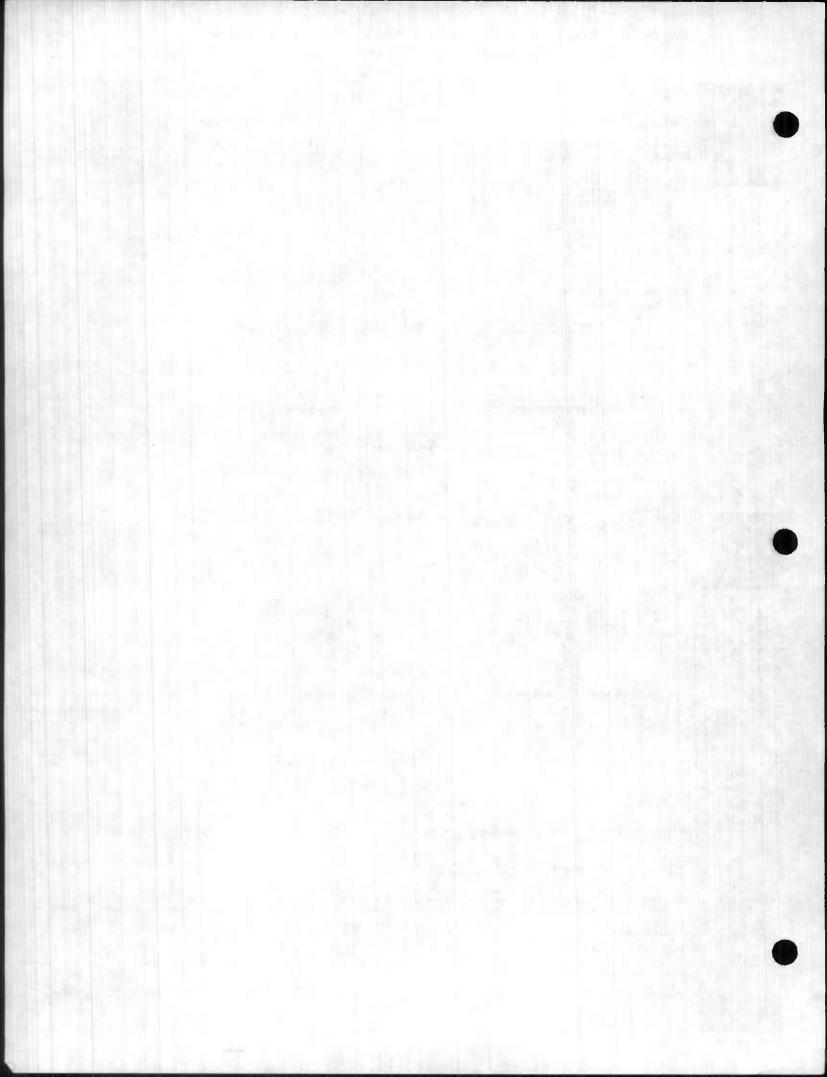
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1	/Medic		Jennie Lee Buck						Octobe			1924pm
	Examin	er	4a Facility Name (If not institution, give					4b. City, Town, or	Location of Deat	h 4c. County	of Deeth	
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	oth with the Merylan 23e or 28e-f show	0	513 Valcour Road				21228		1 2	USA		
Maryland 21215-0020	urs after dee	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X It Yes, Give Year or Dates:			as Decedent of Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		e - Americ ck, White, c White	etc.
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yla	Mend Mend mrke	P	Donald G. Reichli						Helen Bi	-		
Mar	2 sh le m reum		19a. Informant's Name/Relationship (19	b. Mailing	Address (Stree	at and Number or R	ural Route Numb	er, City or Town,	State, Zip	Code)
Baltimore, I	Pages 1 and nent of Health int: If Item 27 iry or other t		Donald G. Reichli 20a. Method of Disposition 1 Burial 2 Deremation 3 D		20b. Place	ot Disposi	Rambling tion (Name of atory or other pla	g Oaks Wa	y Cator Date	20c. Location	MD City or To	21228 wn, State
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Bal	Departme Importar any injur		21. Signature of Funeral Service Licental A. Edward A. Gre	Zynch	4	Cı		ess of Facility of Society erick Roa			D 21	228
	Physician /Medical Examiner	-	Immediate Cause (Final disease or condition resulting in death)	aEPHEDRIN	E INTOXIC		ence of):		9.36		I	Onset and Death
	De isi	nine		b								
,00	tificeta be executed ig physicien end as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury		Due to (or as a	a consequ	ence of):					
68760,	hysic the b	edical	that initiated events resulting in death) Last	C	Due to (or as a	conseque	ence of):					
	No. of	Me		d								
Box	attendin I for use	an	EDUTATION OF	0.			0.00					
P.0.	as thet tha death ceigned by the attendir	y Physician/M	Part II. Other significant conditions of	ontributing to death b	out not resulting	in the und	derlying ceuse g	iven in Part I.		tobacco uas co Yes 2□ No	ntribute to	the cause of death?
Records,	lew requires thet as been signed b	Completed by							24a. Wes	s an eutopsy ormed?	av	ere eutopsy findings allable prior to mpletion of ceuse deeth?
	The law ate has page 2	Eo							180	Yes 2 No	10	Yes 2□ No
of Vital	iclen: The certificate rector, pag	Bec	25. Was cose reterred to medicel examiner?					26. Place of De	eth (Check only	one)		
>	S 00 10	9	Y⊠ Yes 2 No	Hospital: 1 Inpati	ent 2 ER/C	Outpatient	3 DOA	ther: 4 Nursing I	Home 5 Res	idence 6x20th	er (Specif	at scene
	Attending Ph ir deeth. actor: Aftar thi by the funeral		27. Manner of Death 1 Netural 5 Pending 2 Accident investigation	-0,0	y Year) for	Time of Injury 17:05	P 28c. tnj W 1[28d Describe unknown	how injury occur	red	
Division	al or Attends after deeth	Certification:	3 ☑ Suicide 6 ☐ Could not be determined	building, el	jury - At home, tc. <i>(Specify)</i> Apartment	farm, stree	et, factory, office	9		(Street and Number, Stete) 14		ng Oaks Way
	Hospi 14 hou Funer taly fill	edicai (yalcian: To the best inar: On the basis o and manner st	f examination a							
	within 2 To the comple	Ž	29b. Signature and title of certifier	. 01	4		29c. Licer	nse number		29d. Date signe	d (Month,	Day, Year)
			Mounte	reJh	le		O.C.	.M.E.		Octobe	r 09,	2000
N	2		30. Name and address of person who	11) (Type, P	rint)			1,244		
4	(Y		MAKARMOD 1		Ell Hy	0 11:	l Penn s	Street, B	altimor	e, Maryl	and 2	1201
			31 Date filed (Month Day Year)	32 Registr	rar's Signature							

Registrar



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State of Maryland / Department of Health and Mental Hygier	neU U	3	21	U	-
Certificate of Death Reg.	No.				

	Decedent's Nama (First, Middle, Li	st)		061	rtificat	011	J-04111	2. Data of De			3. Tima of Death			
cian	Hazel T. Bit							Month	Day	Yaar	E 20 201			
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20	10e. Street and Number	re	1 6	len Ar	10f. Ziş	Coda			10g. Citizen of	What Country	y?			
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Funeral Director	11. Marital Status	12. Was Decedan Armed Forcas	t Evar in U	,S. 13.				Specify Yas or Norto Ricen, atc.)		ice - Amaricar				
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Ď	17. Fathar's Nama (First, Middla, Las.	,							i, margan Sume	inter				
2	Jason Teter 19a. Informant's Name/Ralationship	Type Print)		19h Maili	no Addres	s (Street		Sohner	ner City or Tow	n Stata Zin C	Code)			
	Anna W. Bittle/S						04							
+	20a. Mathod of Disposition	ISLECTION	20b. F	Place of Disponentary, cran	sition (Na	ma of	ville P	Data	enix, V	- City or Tow	m, Stata			
	1 Burial 2 Cramation 3 E		a l			- 1		i 10-10-00	Polti	mowo	Lin			
-	4 Donation S Other (Specify) Vietro Crematory Inc. 10-10-00 Baltimore, ND 21. Signature Universed Leader 22. Name and Address of Facility Cremation Society of ND, Inc.													
	Dedward A	incl	1											
	23a. Part1. Entar tha diseasa, or con	CILK plications that cause	ed tha daat	h. Do not ani	ar tha mod	da of dyin	g, such as cerdi	d Balti	more, Marrast,	, 1	28 Approximete			
	shock, or haart failura. List only	ona causa on aach	lina.								ntarval Batween Onset and Daath			
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edicai Examiner	rasulting in death) Last		Dua to (o	r as a consec	quanca of):					1				
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-	Part II. Other significant conditions	contributing to death	but not ras	ulting in the u	ndariving	causa niv	en in Part I	23b. Dio	I tobacco use o	ontribute to t	the cause of death			
	Significant sortonions	The state of the s		and an interest	- Lange	y.v			Yes 2□ No					
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	25. Wes case refarred to medical examiner?	112						eath (Check only						
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	27. Mannar of Death 1 Natural 5 □ Panding	28a. Data of In (Month, D	ay Year)	28b. Tima o tnjury	M	28c. Injur Wor	yat k? Yas 2 □ No	28d. Describe	how injury occ	urred				
	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not I	00 00- 0111	niunz - At h	ome ferm st			145 2 140	28f. Location	(Street and Nur	nber or Rural	Routa Number.			
	4 ☐ Homicida determined	building, e	tc. (Specil	y)	ieot, iactor	y, onice			wn, State)		, , , , , , , , , , , , , , , , , , , ,			
100		nysician: To the bas niner: On the basis and manner s	of axamina											
¥		and mannar s	natau.		29	c. Licens	a number		29d. Data sign	ned (Month, D	ay, Year)			
N C	29b. Signature and little of certifier								29c. Licensa number 29d. Data signed (<i>Month, Day, Year</i>)					
Medic	29b. Signature and title of certifiar				T	163	725		101	10/11)			
0	29b. Signature and title of certifiar ———————————————————————————————————		death #4:	024) (7)43	725		101	10100)			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedant's Nama (First, Middla, Last) 2. Date of Death Day **Physician** 6: 40 p.m. Frances Bradford 9 10 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 431 Notre Dame Lane 307 Baltimore N/A Apt If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foraign Country) **Funeral** Days 1 M 20XF 220-20-8290 71 Yrs. Director Md Usual Rasidence of Decedent 10a Slata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show th and Mental Hygiene. 7 is marked other then "natural", or itema 23a or 28a-f ahov traumatic event, the Mapical Examinar must be notified at Md Baltimore Y☐ Yes 2☐ No N/A Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 431 Notre Dame Lane Apt 307 21212 US A Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Raca - Amarican Indian Black, White, etc. 1 Yas ANNO If Yas, Give Yaar or Datas: 1 Nevar Married 2 Married Specify: Black Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Sales Person Lerner Shop 11th grade 18. Mother's Nama (First, Middle, Maidan Sumama) 17. Father's Name (First, Middla, Last) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Item 27 is marked oth
any Injury or other traumatic event David Booze Edna Dillen 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, State, Zip Coda) Patrick Merrick- Daughter 4004 Bowers Avenue Baltimore, Md 21207 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Forest Veteran 10-13-00 Owings Mills, Md Garrison 4 ☐ Donation 5 ☐ Othar (Specify) 21 Sonature of Funaral Service Licenses 22. Name end Address of Facility
March F/H West 4300 Wabash Avenue Baltimore, Md 21215 lications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrast, one cause on each line. 23a Fart1. Entar tha disaesa, or com-nock, or haart failura. List only Approximate Interval Batween Onsat and Death Physician Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury The law requires that the death certificate be axecu ed by the attending physician and detached for use as the bunat-tran Box 68760. that initiated evants rasulting in death) Last Due to (or as a consequence of): P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably Unknown Division of Vital Records. þ 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed phalor Attending Physician: The law ours after death. eral Director: After this certificate has filled in by the funeral director, page 2 1 Yas 200 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Chack only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No Medical Certification: To 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mannar of Death 28c. Injury at Work? Natural 2 Accidant 5 ☐ Panding investigation 1 Yas 2 No 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be 3 Suicida 28a. Place of Injury - At homa, farm, streat, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 29b. Signature and little of certifier

MASTINE 31. Date filed (Month, Day, Year)

OCT

30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print)

1 2 2000

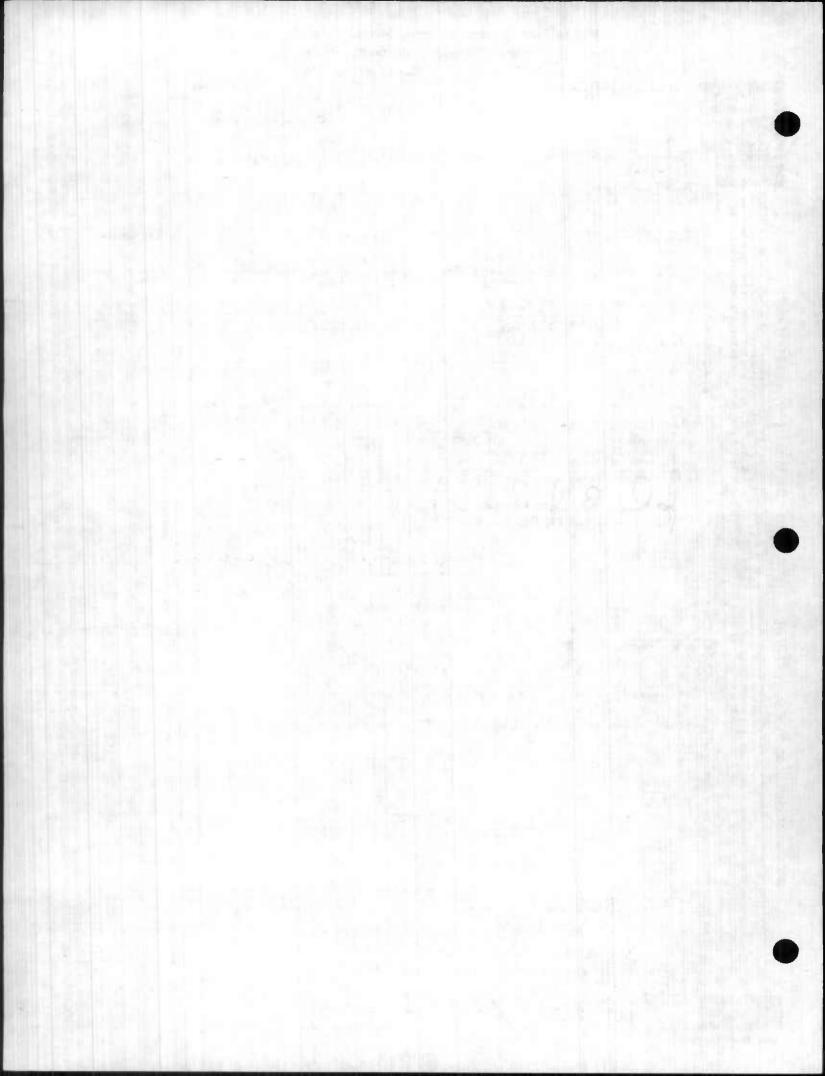
32. Registrar's Signatura

DHMH 16 Rev 6/95

29c. Licansa number

29d. Date signad (Month, Day, Year)

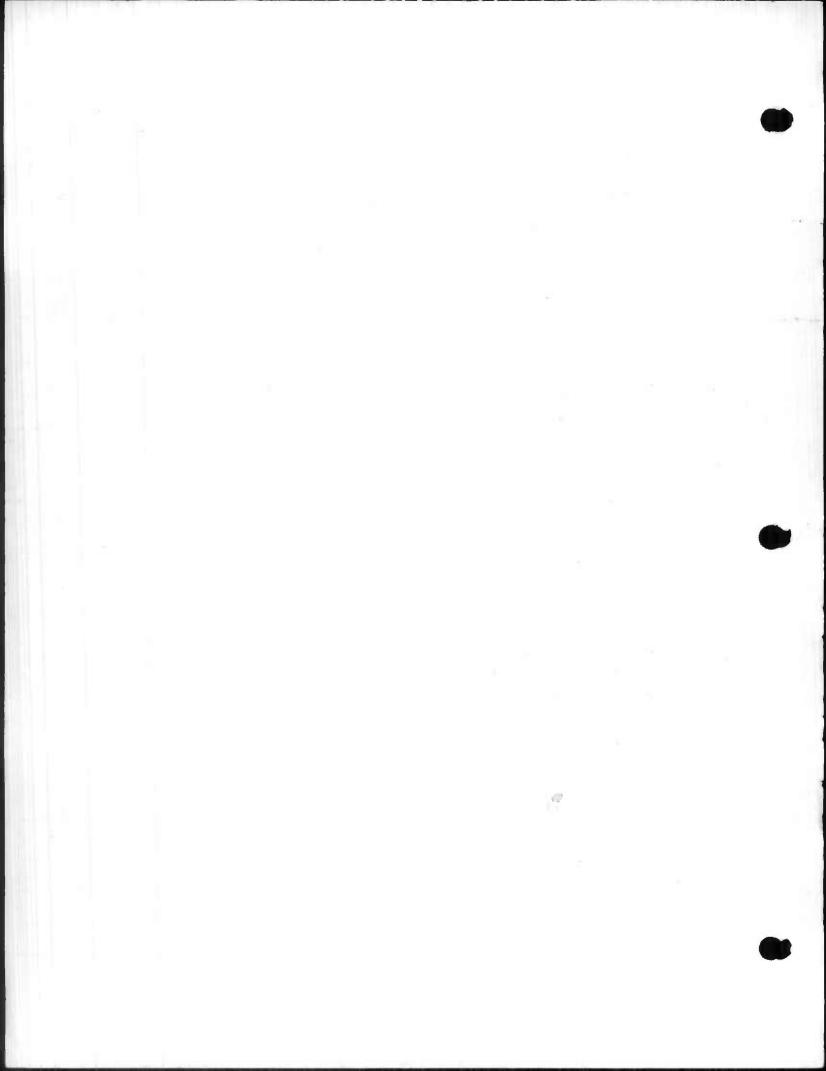
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DIVISION OF VITAL RECORDS, P.O. I	

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH SEP 2:009.M 2000 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year)
9-13-2000 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) DAYS HOURS MIN. NONF 1 🕅 M 2 🗌 F FACILITY NAME (If not institution, give street and number, 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 Himore DWSON HIMORE 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f, ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? 990 3 bunial-transit and 21220 12. WAS DECEDENT EVER IN U.S. ARMED Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cultun, Mexican, Puerto Rican, etc.)

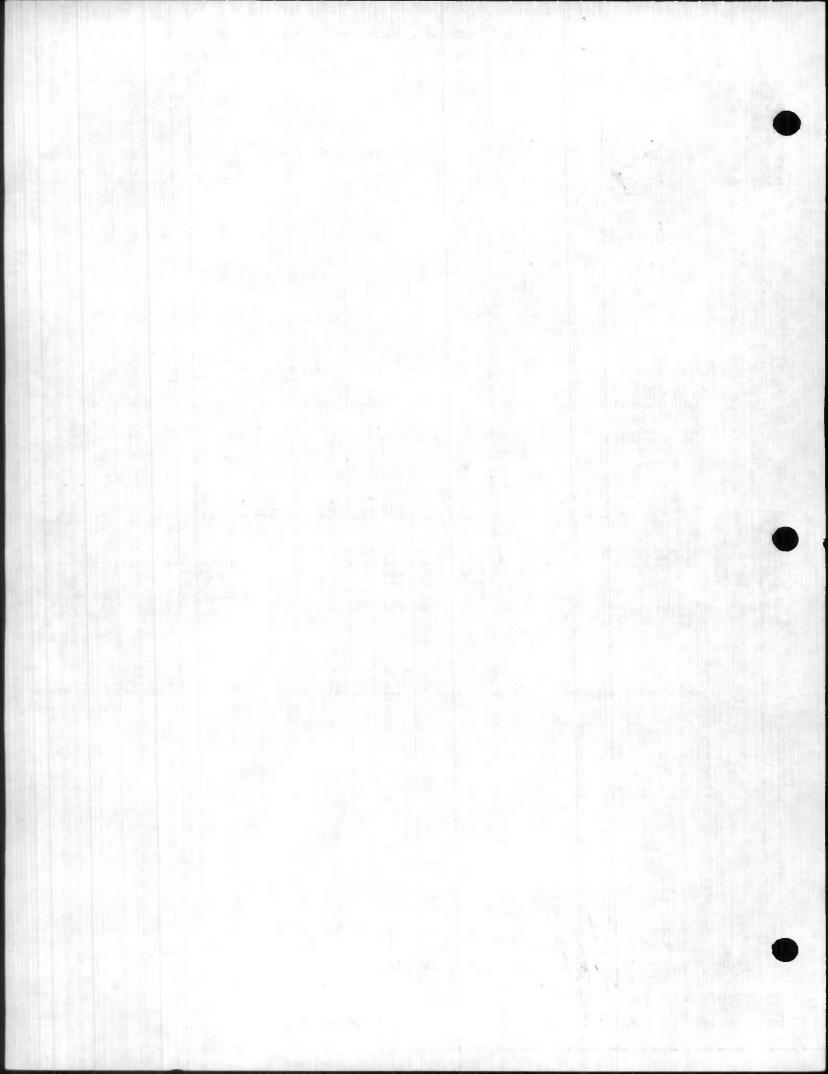
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY the 3 Widowed 4 Divorced use as t ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Give kind of work done to Do NOT use retired. page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, notified at 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, State, Zip Code) RALTO 2 99 havilland e 10 pe 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or OATE must 1 M Buriel 2 Cremation 3 Re 4 Donation 5 Other (Specify) the funeral director, SCHWARTZ CEMETERY 9/18/00 BALTIMORE, MARYLAND medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DAVID WEBER FUNERAL HOMES P.A. DAVID WEBER (PER D.V.R.) 401 S. CHESTER STREET BALTIMORE. MARYLAND 21231 within 24 hours after 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or reepiratory screet, nd completely filled in by bunal, cremation, or remo Approximate ahock, or heart feilura. List only one cause on sech line. intarvai Between 0 **IMMEDIATE CAUSE (Final** Onset and Death the disease or condition recuiting in death) ERINATAL ASPHYCIA 30 mm other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): and (CERTIFICATION Sequentially list conditiona, QUE TO (OR AS A CONSEQUENCE OF): prior to if sny, leading to immediate cause. Enter UNDERLYING physician CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events this certificate has been signed by the attending with the State Dept. of Health and Mental Hygien resulting in death) LAST 6 PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL PREGNANCY shows any 1 TYES 2 TO NO OF DEATH? POORI control 1 TYES 2 TNO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO K UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item EXAMINER? HOSPITAL:
1 Minpatient 2 ER/Outpetient 3 DOA 1 TES 2 NO OTHER: me 5 🗆 Residence 8 🗆 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF 28c. INJURY AT WORK? marked, 1 Natural
2 Accident 1 YES 2 NO DIRECTOR: After the hours after death w BY Investigation 26a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 8 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 28 Item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. TO THE FUNERAL DE FILE WITHIN 72 h 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occured at the time, data and place, end due to the cause(s) end menner se stated. 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month, Day Year) 불 M D 9/21/00 D005/676 orce 2 ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Non. Pint) JEFFREY POMARANCE 6701 NORTH CHARLES STREET TOWSON, MARYLAND 21204 31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE 2 2000



Please Type or Print In Black Indelible Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Ce	ertificat	e of	Death			Reg. No.		
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Funeral	5. Social Security	Number	6. Sex		a (In yrs. last birthda)		r 1 Yaar	If Under		8. Data of Bi (Month, D	rth	9. Birthp	lace (Stata or Foreig
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trau			AUGHTER										ND 21229
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	23a. Part/l. Ente	r the disease, o	or complications	thet causad	tha daath. Do not a	ntar tha mo	da of dyir	g, such es	cardiac	or raspiratory	arrast,		Approximete Interval Batween
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5 P	1 Yas 2	□ No	Hospital:	1 🗆 Inpatie	nt 2 ER/Outpati	ent 3 D	OA Oth	ar: 4 N	ursing Ho	ma 5X Res	idance 6 🗆 O	har (Specif	(y)
After th funeral	27. Mannar of De	eath 5 Pendi		Data of Injur (Month, Day	Year) 28b. Tima	ol	28c. Injur Wor	y at k?		28d. Dascribe	how injury occu	irred	
deeth. ctor: Al y the fu	2 Accident	invasi	tigation			M		Yas 2	No				
by th	3 ☐ Suicide 4 ☐ Homicid	6 ☐ Could determ	minor COU.	Plece of Inju-	ury - At homa, farm, s	traat, factor	y, office			28f. Location	(Street and Num own, Stata)	ber or Run	al Route Number,
de de	4 Homicio			building, atc	. (Зреспу)					City of 70	Jwn, Stata,		
within 24 hours effer deeth. To the Funeral Director: Affer t completely filled in by the funer. Medical Certification:	29a. Certifier (Check only	1 Certifyi	Examiner: On	tha basis of	of my knowledga, daa examination end/or i	th occurred	at tha tir	na, data ar	nd place,	and dua to the	cause(s) and n	nannar as s	itated. o tha cause(s)
within 2 To the complet	one)	1	and	d menner sta	ted.						and Data da		0
To to to to	29b. Signature a	red title of glertiti	1			29	c. Licens	e number		1000	29d. Data sign	ed (Month,	Day, Year)
1800	1	11	1				D.	37343			10-9-	-2000	
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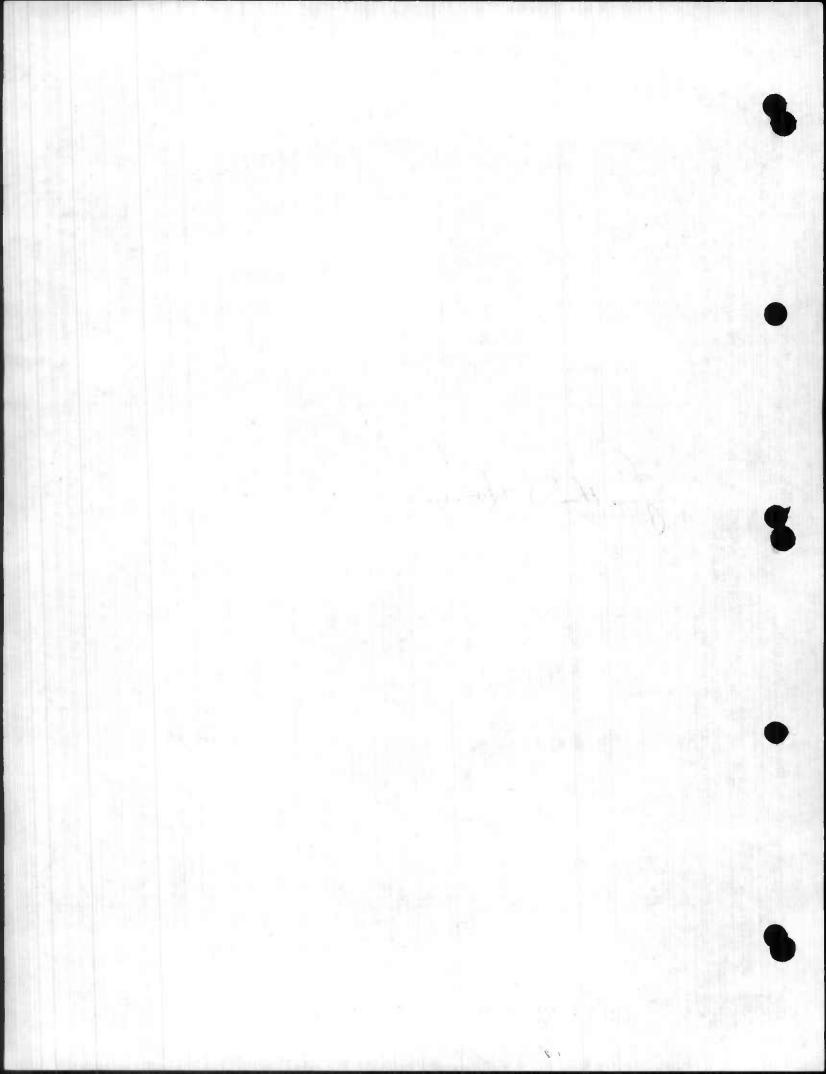
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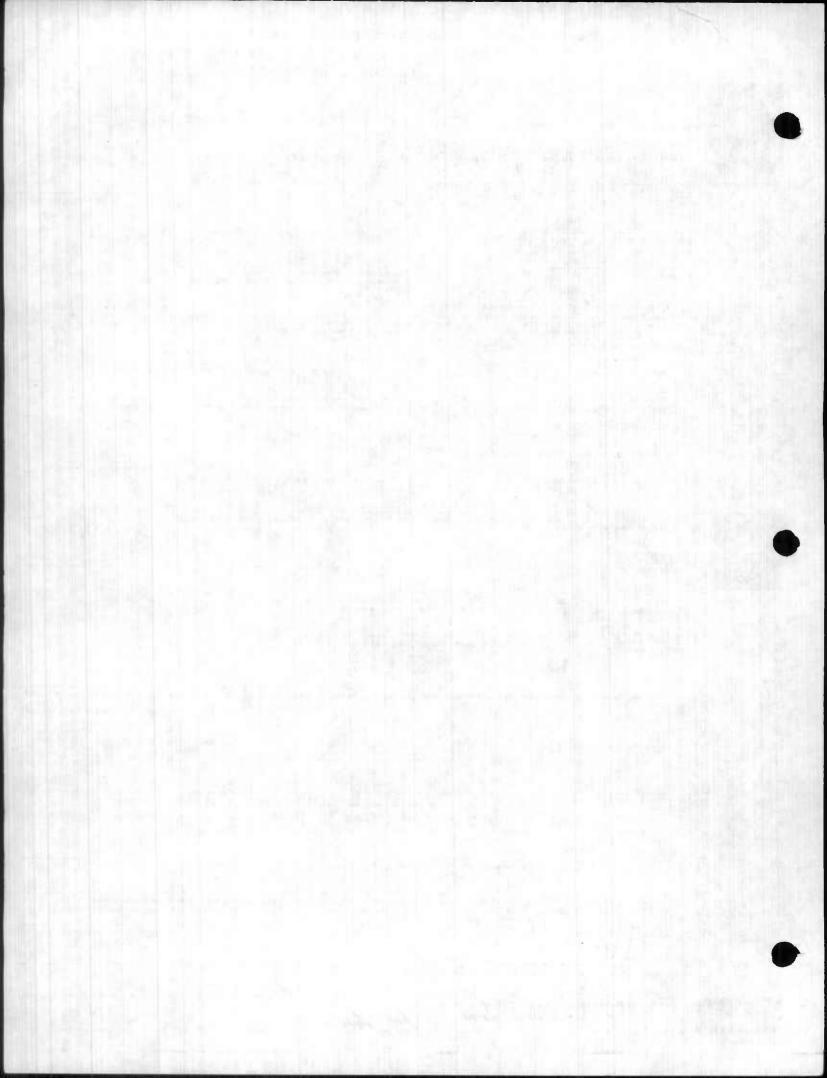
State of Maryland / Department of Health and Mental Hygiene 32 | 6

		Certificate of Death	Reg.	. No.	
Physician	Decedent's Neme (First, Middle, Last)		2. Dete of Deeth Month	Dey Year 3. Time of	of Deeth
/Medical	DOROTHY E. BANKS				Oam
Examiner	4e Facility Neme (If not institution, give street and number)		n, or Location of Death	4c. County of Death	
	LEVINDALE NURSING CENTER 5. Social Security Number 6. Sex 7. Age (In	yrs. lest birthdey) If Under 1 Year If Under 24		N/A	or Fore
Funeral Director	104 205	79 Yrs. Months Deys Hours	8. Dete of Birth (Month, Dey, Ye 10-28-1	9. Birthplece (State Country) 920 MD.	0,70,0
show starting		c. City, Town or Location		10d. fnside (City Lim
to to	MD. N/A	BALTIMORE		1½ Yes	s 2 🗆 I
ms 23a or 28a-f show trained and a contract or contrac	10e. Street end Number	10f. Zip Code	10g.	. Citizen of Whet Country?	
23.0	3325 W. GARRISON AVE.	21215		USA	
Fu Ph	11. Meritel Stetus 1. Never Married 2 Married 1. Never Married 2 Married 1. Yes 2 No 1. Yes 2 No 1. Yes 2 No 1. Yes 7 No 1. Yes 7 Poer or Detes:	in U,S. 13. Wes Decedent of Hispento Origing If Yes, specify Cuban, Mexican, In Yes 2 ☐ Yes Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc. Specify: BLACK	
ygiene. her than "naturn nt, the Wassell Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of	of working	b. Kind of Business/Industry	
than "r	Etementery/Secondary (0-12) Cottege (1-4or 5+)	(Give kind of work done during most of life. DO NOT use retired)	n working		
Hygier the mrt, tra	-120-	HOUSEKEEPING	s Neme (First, Middle, Mai	DOMESTIC	
Be see	17. Fether's Neme (First, Middle, Last) RICHARD BANKS		A BEALE	iden Sumeme)	
Department of Hauth and Mentel Hygiene. Important: If them 27 is marked other than "natural; any Injury or other traumatic avent, the Medical Exponen. To Be Completed by	19e. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street end Number		City or Town, State, Zip Code)	
27 la 27 la or trai	MURIEL ARMSTEAD(SISTER)	3325 W. GARRISON A	AVE. BALTIMO	RE, MARYLAND 21	215
tem to the		Ob. Plece of Disposition (Name of cametery, cremetory or other plece)	Date 200	c. Location - City or Town, State	
In our of the our of t	1 X Burial 2 Cremetion 3 Removel from State 4 Donation 5 Dother (Specify)	T. CALVARY CEMETERY	10-14-2000	GLEN BURNIE, M	D.
y Inju	21. Sonahmyot Funeral Service Licensee	22. Name end Address of Fecility			
8858	I was the J. Huss	1721-27 N. MONROE	E ST. BALTIMO	ORE, MARYLAND 2	121
g physician end as the burial-transit addical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury c.	to (or es e consequence of):			
2 2	resulting in death) Last Due Part II. Other significant conditions contributing to death but no	to (or es e consequence of):	23h Did toha	acco use contribute to the cause	e of de
igned by the attendible detached for use	Part II. Other arginicant conditions contributing to death out no	(toouting in the unconying couse given in tent.			Unkr
s been s 2 should pleted			24a. Wes en e performe		r to
te has page 2	Charles Arrived March		1 ☐ Yes	2 10 1 Yes 20	□ No
certificate rector, pag	25. Wes case referred to medical examiner?		of Deeth (Check only one)		
this carried direction To	1 Yes 2 No Hospitel: 1 Inpatient		sing Home 5 Residence		
or death. art death. better: After this certification; To Be (27. Menner of Death 1 Maturel 5 Pending (Month, Day Yes	ar) 28b. Time of Injury Mork? M 28c. tnjury et Work? 1 Yes 2 N	28d. Describe how	injury occurred	
s after de il Directo ed in by t	3 Suicide 6 Could not be determined 28e. Plece of Injury - building, etc. (S)	At home, ferm, street, fectory, office pecify)	28f. Location (Stree City or Town, S	et end Number or Rural Route Nu Stete)	imber.
within 24 hours after death. To the Funeral Director: After this certificate ha complately filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my one) 1 Medical Examiner: On the basis of examend menner steted.	knowledge, deeth occurred at the time, date and mination and/or investigation, in my opinion, death	plece, end due to the ceus a occurred et the time, dete	se(s) end menner es stated. e end plece, and due to the cause	e(s)
within or the comple	29b. Signeture end title of certifier	29c. License number	29d	I. Date signed (Month, Dey, Year)	
	My My	D47687	3	0/10/00	
10	30. Name and eddress of person who completed ceuse of deeth			11-1	11
	1 0 Mi 25 Maid	+ Suite Zoo Renkola.	MO		
State	31. Date filed (Month, Day, Year) 32. Registrer's 5	Signeture		Name 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	
State Registrar	Raymond Millio 25 Main stree	+ Suite Zoo Ruskolowa	Mo		

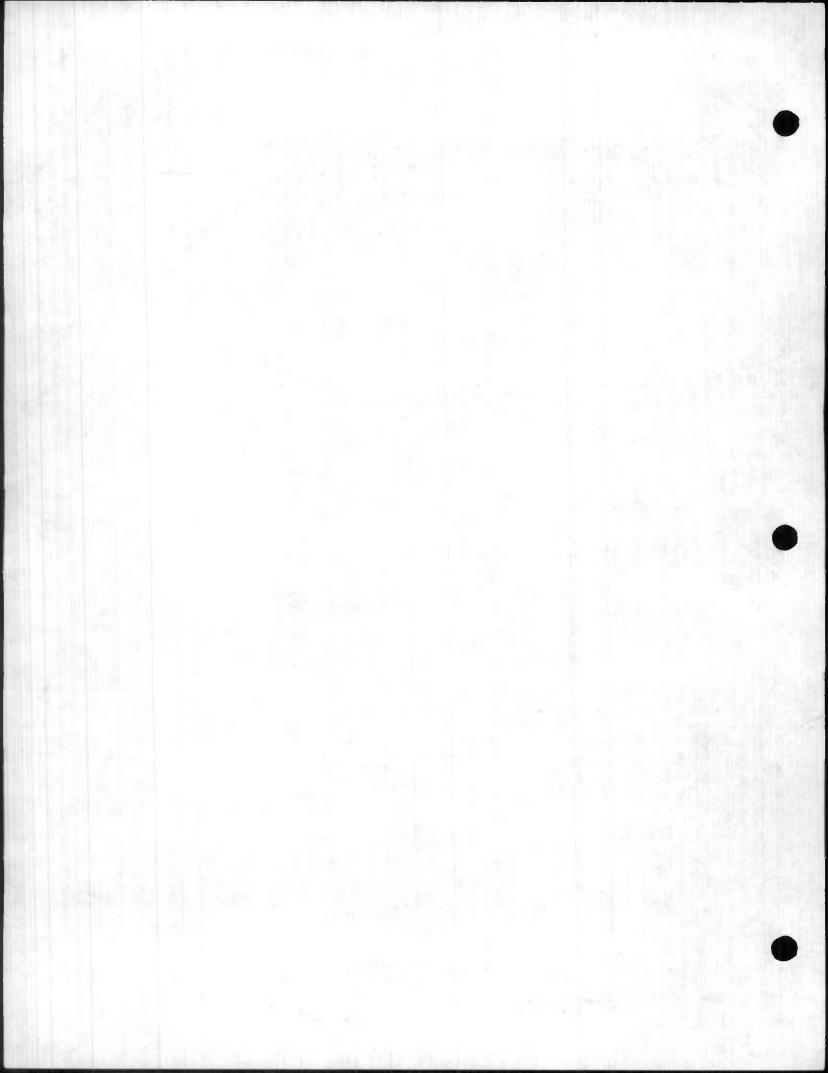


State of Maryland / Department of Health and Mental Hygiene 00 32 107

		D- 8 41		Certific	ate of	Death	,	leg. No.		0. The 1/0
ian	1. Decedent's Nama (First, Midd			Dank			2. Date of Dea Month	Day	Yaar	3. Tima of Death
al	Clara	Mae	- 15.5	Barto	on		Oct.	-	2000	12:15 am
ner	4a Facility Nama (If not institution					4b. City, Town, or Lo	ocation of Deeth	4c. County	of Death	
	Genesis Elde					Dundalk		Balt		
	5. Social Security Number	6. Sex 1 □ M 2 🗚 F	Age (In yrs.	Mont	hs Deys		8. Deta of Birth (Month, Day	Year)	9. Birthpla Country	ca (Stata or Foreign
	226-16-5400 Usual Rasidence of Decedent	.0 240	78	Yrs.			Dec.	1,1921	Va.	
	10a. Stata 10b. County	,	10c. Cit	y, Town or Location					100	d. Insida City Limits
to	Md. Balt	imore		undalk						1 Yas 2 No
Funeral Director	10e. Street and Number			10f.	Zip Coda		1	0g. Citizen of V	Vhet Countr	y?
0	7589 Ives La	ne Apt A			21222	2	David Co.	USA		
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DA LO	1 Nevar Married 2 Mar 3 Widowed 4 Divorced	If Yas Giva	No		s 2 No		rican, atc.)	Specify	ek, Whita, at Whit	
000	15. Deceder	nt's Education		16a. Decedant's l	Jsual Occu	pation	. 1	16b. Kind of Bu	ısinass/îndu	istry
ğ	(Specify only highs Elementery/Secondary (0-12)	st grada complated)	v E . \	(Giva kind of lifa. DO NO	f work dona T usa ratire	during most of work	ing			
5	8 yrs.	College (1-4d	J. 34)	Housew	ife			Own H	ome	
o Be Completed	17. Father's Neme (First, Middle,	Last)				18. Mother's Nam	a (First, Middla,	Maidan Sumam	na)	
5	Walter Barb	aur				Elise	Durl	nam		
	19a. Informant's Name/Ralations	ship (Type, Print)	F20 51	19b. Mailing Add	rass (Stree	t and Number or Rui	al Routa Numbe	r, City or Town,	Stete, Zip C	Code)
	Carolyn Vite	k Nie	ce	7589 I	ves 1	Lane Apt	A. Dui	ndalk.	Md.	21222
	20a. Mathod of Disposition		20b. F	Place of Disposition (camatary, cramatory			Data	20c. Location -		
	1 Burlai 2 Crametion 4 Donation 5 Other (5	3 Ramovel from Sta	10	amatary, cramatory Lyview Ci		U	ct 11,	De1+2		Ci b
	21. Signature of Funaral Sarvice		Do			ass of Facility	2000	Balti	more	CITY
	Anthon	y Con	relli	Conne	elly	Funeral lers Poi	Home ont Rd.	of Dunda	dalk,	P.A. 1d. 21222
	23a. Part 1 Enter the common shock, or haart failura. Un	complications that cause	sed tha daat	Do not antar tha	moda of dy	ing, such es cardiac	or raspiratory are	rast,		Approximate Interval Between
н	Shock, of Haart failura.	only ona cause on aad	i iiria.	U						Onsat and Death
	Immedieta Cause (Final diseasa or condition	Cara	inomo	of Tun					2	
	rasulting In death)	a. Carc.		of Lunc					13	years
Jer		Chro				Pulmonar	y Diac	250	120) 40000
edical Examiner	0	b. CIII O				urmonar	y Disea	156	120) years
LYB	if any, leading to immediate	1000	Dua to (C	or as e consequance	OI).				1	
182	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events	С.	Dura to f		af).					
5	rasulting in death) Last		Dua to (o	r as a consequanca	or):					
		d					111111111111111111111111111111111111111			
Clai	D H Oth						1			Mar agus - 4 - 1 - 1
Physician/M	Part II. Other significant conditi		but not ras	ulting in the underlyi	ng cause g	iven in Part I.				ths causs of death?
	Hypertensi	on					101	ras 2∐ No	3 ☐ Prob	ably 4 Unknown
	D. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	- 7.7.4					24e Was	an autopsy	24b. Wer	re eutopsy findings
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Completed by										éeth?
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)	1 ☐ Yas 2 No	Hospital:			DUA		ome 5 Resid)
-	27. Mannar of Death 1 Natural 5 ☐ Pendi	28a. Data of I (Month,	njury Day Year)	28b. Tima of Injury	28c. Inju		28d. Dascribe h	ow injury occur	red	
atk	2 Accident Invast	igation		М		Yas 2□No				
	3 ☐ Suicida 6 ☐ Could detam	nined 200. Place of	Injury - At he atc. (Specif	oma, ferm, street, fa	ctory, office		28f. Location (S City or Tow		per or Rural	Routa Number,
) el	4 LI Homeda	building,	att. (Specii	7/			Only or 10W	., ciuto/		
ai	29a. Certifier 1⊠ Certifyi	ng Physician: To the be	st of my kno	wiedge, deeth occur	red et the t	ime, deta end plece,	end due to the	euse(s) end ma	anner es ste	eted.
Medical Certification:	(Check only 2 Medical one)	Examiner: On the basis	of axamina	tion and/or Invastiga	ition, in my	opinion, deeth occur	red at tha tima, o	deta end piece,	and due to	the cause(s)
Me	29b. Signature and little of certific	0	1	14118		isa number		29d. Data signe		
	1 Atur	mymx	n	am.	Ι	00014160		10/11	/2000)
	20 Name and address of	1	A do odi da	200) (Turn Drive						
	30. Nama and addrasa of person				10			F. J		
	Harjit Sin	ign, M.D.	5410	-A Ritch	ne H	lighway E	saltimo	re, Mo	21	225
ate	31. Data filed (Month Pay, Year,	2 2000 32. 100	strar's Signa	liura La	1					



Amended Ite	m#8 perFHG788 10/30/200			tificate of		тептат пу	Reg. No.	32100	
Physician /Medical	1. Decedent's Name (First, Middle, Las Ernest B. Carter	"				2. Dete of De Month	P. 10, 20	Year 9:16 am	
Examiner Funeral Director	5. Social Security Number 6. Se	JOEL HOS	SPITAL rs. lest birthday) 86 Yrs.	if Under 1 Year Months Deys		PNIE	AACC	of Deeth OUNTY 9. Birthplace (State or Foreign County) Virginia	
g	Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or Location					10d. toside City Limits		
4 sho	Maryland Anne Arundel		Severn				1 Yes 2 No		
or 28a-f. be notified Directo	10e. Street end Number		10f. Zip Code				10g. Citizen of Whet Country?		
	7959 Telegraph Roa	ad Lot 142	2 21144				US	SA	
by Funeral	11. Maritet Stetus 1 Never Merried Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 7 Yes 2 No If Yes, Give Yeer or Detes: 42 -		Vas Decedent of Yes, specify Cut	Hispenic Origin? (Spoen, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race Bleck Specify:	- American Indian, K, White, etc. White	
Completed	15. Decedent's Edi (Specity only highest grad Elementery/Secondary (0-12)	cation	16e. Decedent's Usuel Occupetion (Give kind of work done during most of working lifte. DO NOT use retired)			ing	16b. Kind of Business/Industry Government		
Be Cc					e (First, Middle	, Meiden Sumeme			
OB	Woody W. Carter Claude (G. Frost			
	19a. Informent's Neme/Reletionship (T	ype, Print)	19b. Mailir	g Address (Stree	t end Number or Run	el Route Number, City or Town, State, Zip Code)			
	Ernest M. Carter 20a. Method of Disposition The Burial 2 Cremetion 3 I all 4 Operation 5 Other (Specify	20b Removel from State	. Place of Dispo cemetery, cren		ece)	ad Rest	20c. Location - (zinia 20191 City or Town, State onville, Maryland	
for use as the burial-transit and position of the purial position of	Immediate Cause (Final disease or condition resulting in death) Begunntially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of):								
clar	D. att. Cab				Las to Book	ORL DIA	A-b	Adhua as the same of death &	
by Physician/M	Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.					23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 4 Anknown			
2 should							an autopsy ormed?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?	
							Yes 2010	1 ☐ Yes 2 ☐ No	
To Be	25. Wes cese referred to medicel examiner? 1 Yes 2 No 27. Manner of Deeth	iner? fes 2 No Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing H					one) dence 6 Othe how injury occurre		
completely filled in by the funer	1 Netural 5 Pending investigation 3 Suicide 4 Homlcide 5 Could not be determined	(Month, Dey Year) Injury Work? Injury Work? 1 □ Yes 2 □ No			28f. Location (Street and Number or Rural Route Number, City or Town, Stete)				
pletely filled edical C	29e. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the ceuse(s) and menner stated.								
Med	29b. Signature and title of certifier 29c. License number						29d. Date signed (Month, Dey, Year)		
0) Zavoz D 21776						OCTOBER 11, 2000		
	D 21776 OCTOBER 11, 2000 30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) SURVEY MUNDRA WD 3001 S. HANDVOX ST BACTI MINE 2123								
State Registrar	31. Dete filed (Month Cox, Year) 2	2000 32. Registrat's Sig	neture	5 So	2.15	4			

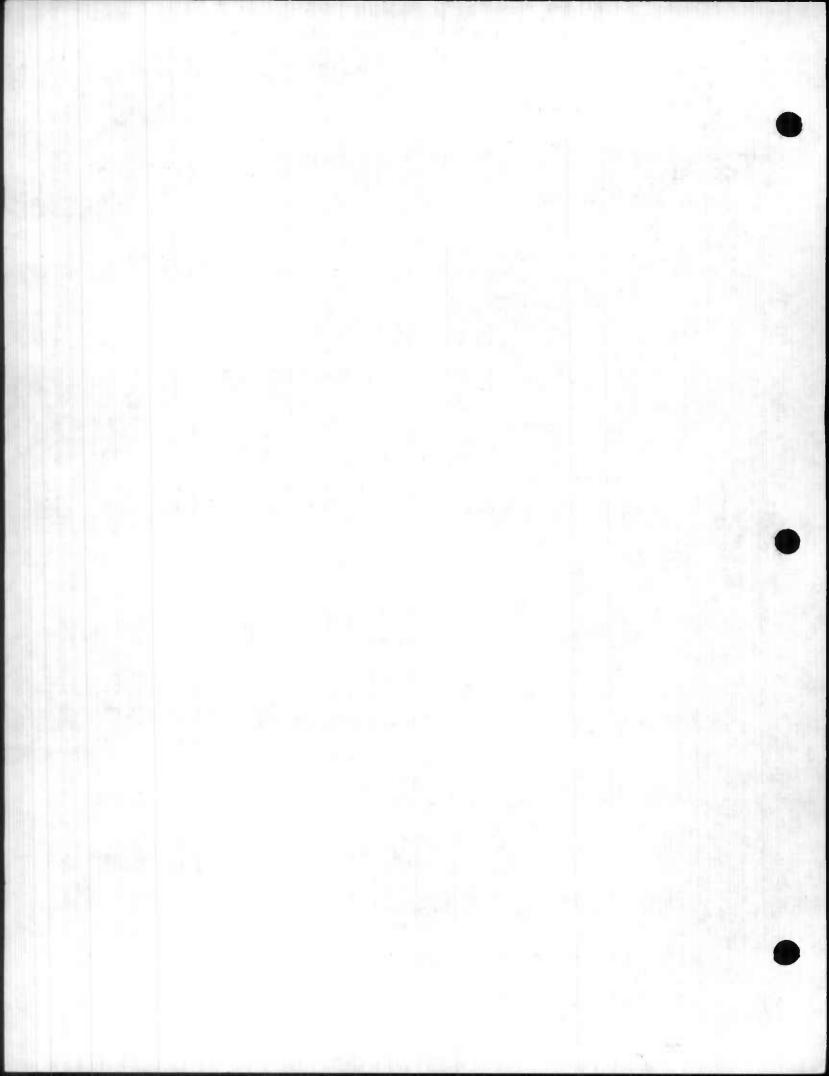


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Beatrice Pauline Crolius Oct. 10, 2000 3:20 p.m. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner 9010 Briarcroft Lane Prince George Laurel If Under 24 Hrs. If Under 1 Year T 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 87 Yrs 140-03-8282 Director June 17,1913 Vermont Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ral', or herna 23a or 28a-f ahow Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9010 Briarcroft Lane 20708 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Married "natural", or h Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry permit. Peges 1 and 2 should be filed within: Department of Health end Mental Hygiene. Important: If them 27 is marked other than "reagy Injury or other traumatic event, me Health Elementery/Secondery (0-12) College (1-4or 5+) Assistant Pharmacy 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Geiger Phoebe Lambert 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4658 Dower Drive, Ellicott City, Maryland 21043 Valerie Geiger/Daughter 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1X Buriel 2 Cremetion 3 Removel from State 10/13/00 Columbia, Maryland Columbia memorial 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Pert1. Enter the disease accomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Ceuse (Finel diseese or condition resulting in deeth) /Medical PANCRETTIC CANCER 2 MONTH Examiner Due to (or es e consequence of) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? ate has been signed by the page 2 should be detach 3 Probably 4 Unknown 1 Yes 2 No Records. Be Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 28 No 1 ☐ Yes 2 No 1 ☐ Yes Division of Vital or Attending Physicien: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home Seridence 6 Other (Specify) 1 Yes 2No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Day Year) 27. Menger of Deeth 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred After 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No deeth. Hospital or Attending 24 hours after deeth
 Funeral Director: A 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide filled in Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steled. 29e. Certifier completely (Check only one) To the To the To the F 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sochelle D45014 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Contary Line 8379 SABELLA LAURIA NO 20707 1ARTIRE 32. Registrar's Signatura State Registrar

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end Item .	23a, 27, 28a, b, c, d, e, f po		723/00 yf Ce	rtificate	of Death	2. Deta of	Reg. No.	2	. Time of Death
Physician /Medical	Mark Allen C	ollins				Month OCTOE	Day BER 10, 2	Yaar 000	1938 PM
Examiner	4a Facility Nema (If not Institution, gi 8229 FOREST GLI				4b. City, Town, or				
uneral irector	5. Sociel Security Number 6.		34 Yrs.	If Under 1 Y Months D	PASADEN ear If Under 24 Hrs eys Hours Min	8. Dete of	Birth	9. Birthplece Gountry) Mary	(Stete or Foreign
rector	Usuel Residence of Decedent 10e, State 10b, County		10c. City, Town or L	ocation				10d.	Inside City Limits
tor		Arundel	Pasad						1 ☐ Yes 2 ☐ No
irec	10e. Street end Number	il didei		10f. Zip Co	de		10g. Citizen of \	-	?
rai	8229 Forest Gle	n Drive			21122	311.5	U.S.		
by Funeral Director	11. Meritel Status 1 Naver Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedant & Armed Forces? 1 Yes 2 N If Yes, Give Year or Detes:	Evar in U,S. 13.	Wes Decedent If Yes, specify 1 Yes 2 X	of Hispanic Orlgin? (: Cuben, Maxican, Puer No Specify:	Specify Yes or to Rican, etc.)	No- 14. Rad Blee Specify	a - American I ck, White, etc.	
		Education	16e. Deci	edent's Usuel O	ccupetion	orkino	16b. Kind of B	usiness/Indust	try
Be Completed	(Specify only highest gi	College (1-4or 5	+) life.	Boiler			Union		
To Be	17. Fether's Nema (First, Middla, Las Charles David C					me (First, Mide Sosnow	dle, Maiden Sumen SKİ	ne)	
	19e. Informent's Neme/Reletionship				reet end Number or R				
	Joan Roberts (Mo 20e. Method of Disposition 1 🗆 Burial 2 🛱 Cramation 3	☐Removel from Steta	20b. Plece of Disc	osition (Neme o	r plece)	Dete	more, Mary 20c. Location 0 Baltimo	City or Town,	, Stata
	4 Donetion 5 Other (Spec								J Talla
any injury or other traumatic event, once. To Be C	21. Signatura di Tanana	TOTAL	4/2	cCully-	ddress of Fecility Polyniak Patapsco Av	uneral	Home, P. A		
ician dical niner	Immediate Cause (Final disease or condition resulting in death)		INTOXICATIO						nset end Death
dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	c	Due to (or es e conse						
Physician/Me		d							
detached for usa a	Pert ii. Other eignificant conditions	contributing to death bu	it not rasulting in the	underlying caus	e given in Pert I.		old tobacco use co		
by Ph						1	Yee 2 No	3 Probab	Unknown
Completed b			10.7	1100		24a. W	les en eutopsy erformed?	eveile	eutopsy findings ble prior to letion of causa eth?
ollector, page To Be Com						t	Yes 2□No	DOV	es 2 No
Be	25. Wes case referred to medical examiner?	Hospital:			26. Place of De	eth (Check or	nly one)	7	
funaral dire		Hospitel: 1 ☐ Inpatie 28a. Dete of Injure (Month, De) found:	Year) 28b. Time Injury unknown	of 28c.	Injury at Work?	Home 5 R	esidenca 6 XIOth be how injury occur	ner (Specify) rred unkno	AT SCENE
plately filled in by the funared edical Certification:	2 Accident Investigeti 3 Suicide 6 Could not 4 Homicide	be 202 Place of lain	0/00 ury - At home, farm, s :. (Specify)	treet, fectory, of	fica	28f. Location City or Pasader	on (Street end Num Town, Stete) 82	per or Rurel R 29 Fores:	t Glenn Dr.
complately filled in by tha funaral Medical Certification: 1	29a. Certifier (Check only one) 1 Certifying P	hyeician: To the best of miner: On the basis of and mannar ste	examination end/or i	th occurred et the	he time, dete end pled my opinion, deeth occ	a, end due to t curred et the tir	the cause(s) and m na, dete end pleca,	enner es state and due to the	ed. a ceuse(s)
Сом		10			cense number		29d. Date signe		
	30. Name and address of person who	completed cause of de	eeth (Item 23a) (Type		OCME		OCTOBE	CR 11,	2000
	J. LARON LOS	to MD	111/	Ponn /bu					
State	31. Data filed (Month Pay, Year)	DDD 32. Régistra	u'a Sighature	190	part,	miore,	Maryland	1 21201	

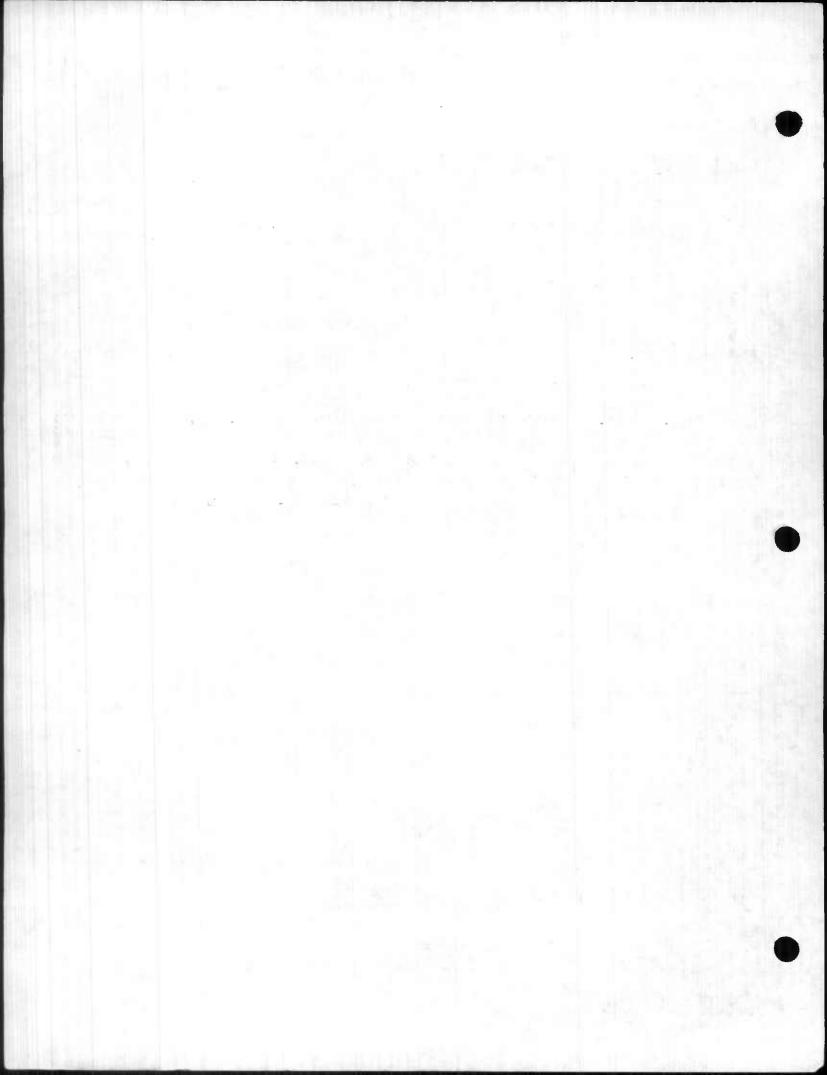


State of Maryland / Department of Health and Mental Hygiene 00 221

	II,27 per me G790 12/19/00 yf Certificate of Death 1. Decedent's Nama (First, Middla, Last)	Reg. . Data of Death	. No.	3. Time	of Death
Physician		Month October	Day 09, 20	Yaar	9 A.M.
/Medical			4c. County o		9 A.M.
Examiner	4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Loca 8607 Woodville Road Mount Ai			erick	
		. Data of Birth			la or Foreign
uneral Pirector	217 F2 0107 1 M 28 F 51 Vrs Months Days Hours Min.	(Month, Day, Youne 30,		9. Birthplaca (Sta Country) Virginia	
B 16	10a. State 10b. County 10c. City, Town or Location			10d. Inside	City Limits
23e or 28e-f ahow ust be notified at rai Director	Maryland Frederick Mt. Ai	×11		1 🗆 Y	as 2∱ No
be noulled Director	10e. Street and Number 10f. Zip Coda		. Citizen of Wi	nat Country?	
0 G	8607 Woodville Road 21771		United	States	
dreg must	11. Marital Status 12. Was Decedant Evar in U,S. Armad Forcas? 13. Was Decedent of Hispanic Origin? (Specific Yas, specify Cuban, Mexican, Puarto Ri	fy Yas or No-		- Amarican Indian Whita, atc.	,
by E	1 Nevar Married 1 Yas 2 No	oan, atc.,	Specify:	White	
rt, the Medical	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	16	b. Kind of Bus	inass/Industry	
men	Elementary/Secondary (0-12) College (1-4or 5+)				
S P	12 Years 4 Years Registered Nurse			Care Pro	ovider
	17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama ()	
	7 03	Hawkin			
or traumatic	Mr. Gary D. Campbell (Husband) 19b. Mailing Addrass (Straat and Number or Rural in 8607 Woodville Road M	Route Number, C It. Airy			771
other of	20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place)	Data 20	c. Location - C	City or Town, State	
Important: If i any injury or pose.	1 Burial 2 Stramation 3 Removal from Stata 4 Donation 5 Dother (Specify) Hilltop Service Corp. 10/13	3/2000	Towson	n, Maryla	and
Important: I any Injury o once.	21. Signature of Fundal Service Licenses 22. Name and Address of Facility			-	
eny Pope	Duda-Ruck Funeral				
	7922 Wise Ave. Dur. The Complete the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.			Approxi	nate
sician	whoch, or heart failura. List only one causa on each lina.			Onset a	Batween nd Death
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چ ا	Dua to (or as a consequence or).				
ial-transit Examiner	Sequentially list conditions. Due to (or as a consequence of):				
EX EX	Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disasas or Injury that initiated evants Dua to (or as a consequence of):			4	
physician and strength bund-transit bund-tra	Cause (Disaasa or Injury c. that initiated evants rasulting in daath) Last Dua to (or as a consequence of):			P2	
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r use	d.				
d by the attendin letached for use Physician/M	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did toba	acco use conf	tribute to the cau	ee of death?
should be detached leted by Physical		1 ☐ Yee	2.20 No	3 Probably	Unknow
b b					
page 2 should		24a. Was an a	autopsy ed?	24b. Wera autop available pr	or to
2 sh				completion of death?	of causa
egec COT		1 🔀 Yas	2□No	1 PYes	2□ No
i certificate hes b lirector, page 2 s o Be Compil	25. Was case referred to medical 26. Placa of Death (Check only one)			
	examinar? 1X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	s 5 Rasidano	ce 6 DOtha	(Specify) a+	scene
er this heral di	27. Mannar of Death 28a. Date of Injury 28b. Tima of 28c. Injury at 28	d. Dascribe how			SCELLE.
atio	1125Natural 5 ☐ Panding (Month, Day Year) Injury WORK? 2 ☐ Accident invastigation M 1 ☐ Yas 2 ☐ No				
led in by the funers Certification:	3 ☐ Suicida 6 ☐ Could not be datarmined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)	f. Location (Stra. City or Town,		r or Rural Routa I	vumber,
d in	obinding, atc. (Specify)	ony or ronny			
To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	29a. Cartiflar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an manner: On the basis of axamination and/or Invastigation, in my opinion, death occurred and manner stated.	d due to the cau at tha tima, data	se(s) and mar a and placa, a	nnar as stated. nd due to tha cau	sa(s)
Me Me	29b. Signature and title of cartiflar 29c. Licansa number	290	d. Data signed	(Month, Day, Yea	r)
	At A A Made a O.C.M.E.	Oc	ctober	10, 2000	
	30. Nama and addrass of person who complated cause of death (New 23a) (Type, Print) 111 Penn Street, Bo				
		altimore	e, Mary	land 212	01
	31. Data filled (Month, Day, Year) 32. Registra's Signatura				
State	or. Data mod (moral, Day, rear)				

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ORIGINAL



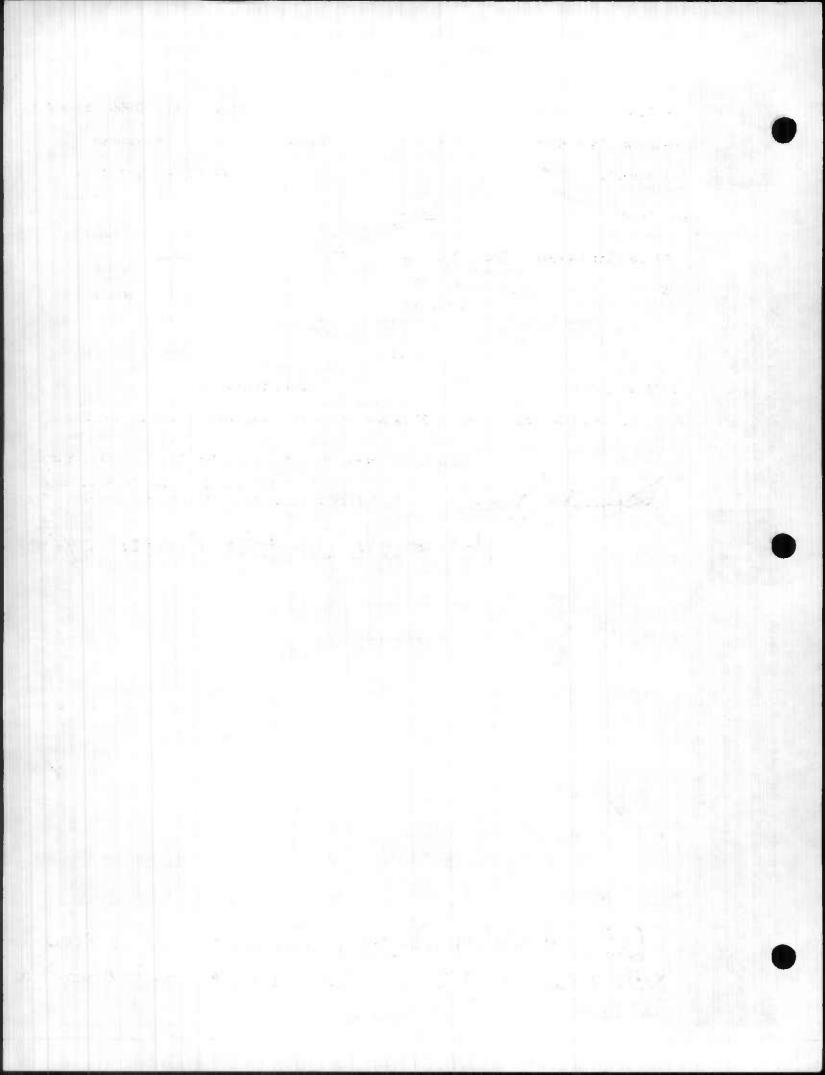
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Month Yee **Physician** 5:40 A.M. Oct. 11 2000 Philmore Corbin /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner Baltimore Parkville Genesis Elder Care If Under 1 Yeer 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In vrs. lest birthdev) If Under 24 Hrs. Birthplece (State or Foreign Country) 6. Sex **Funeral** Hours Days Months **™** 2□ F Director 07/22/1928 Maryland 72 212-22-3260 Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a Stete 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumstic event, the Medical Examiner must be notified at 1X Yes 2 No Baltimore Maryland Directo 10a. Citizen of Whet Country? 10e. Street end Number 10f, Zip Code Apt. 1304 21217 U.S.A. 501 Dolphin Street Funeral daath 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 / 7 / Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Armed Forces? 1/7/49

1 Kres 2 No
If Yes, Give
Yeer or Detes: 6/11/52 filed within 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: Baltimore, Maryland 21215-0020 Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pegas 1 and 2 should be filled within nant of Haalth and Mantal Hygiana. nt: If Item 27 is marked other than Elementery/Secondary (0-12) College (1-4or 5+) 8 Bakery Baker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be William Corbin Viola Campbell 19a Informent's Neme/Relationship (Type Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3058 Ascension St., Baltimore, Maryland 21225 Nimat M. Abdul-Salaam / Niece other 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Buriel 2 Cremetion 3 Removel from State injury or Garrison Forest VA Ceme. 10/17/00 Owings Mills, Maryland 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Fecility 21. Signature of Funeral Service Lines Derrick C. Jones Funeral Home 5 4611 Park Heights Ave., Baltimore, Maryland 21215 Approximate Intervel Between Onset end Death 23a. Pert1. Enter the disease, or complications viat caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one change on each line. 4 Cons **Physician** ata Concer /Medical tmmediate Cause (Finel diseese or condition resulting in death) Examiner Due to (or as e consequence of) Examiner requires that the deeth cartificeta be executed buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest pue Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the Due to (or as e consequence of) SS ettanding USB ŏ signed by tha e 23b. Did tobacco usa contributa to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown p 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy paga 2 1 TYes 2 No 2 MNO 1 T Ves certificate director, 25. Wes case referred to medical Be 28. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manger of Deeth 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred Certification: Aftar 5 Pending investigation 1 Naturel i or Attending after death. Director: After 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI completely filled in 1 Certifying Phyelclan: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end manner es steted.

2 Medical Examinar: On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number Parkway Balton Dro 214k (Item 23e) (Type, Print) idress of person who completed cause of deet 300 B 31. Dete filed (Month, Dey, Yeer) OCT 1 2 2000 32. Registrer's Signature State

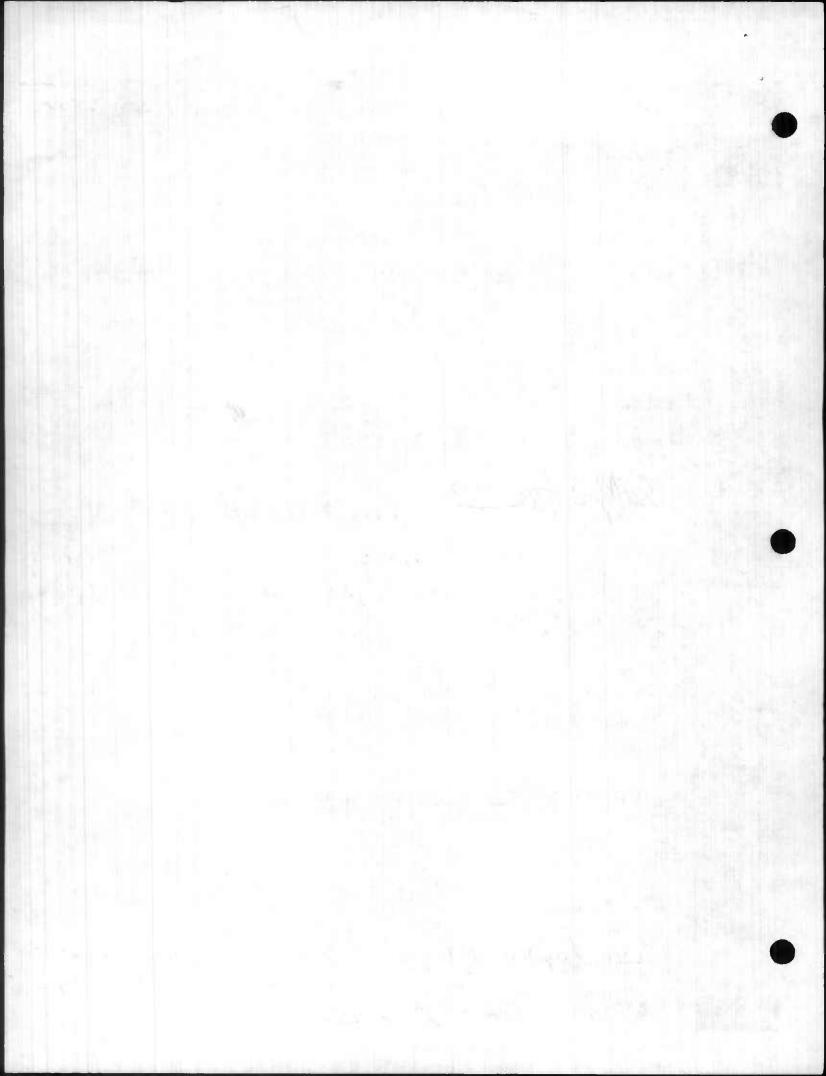
DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 0 22113

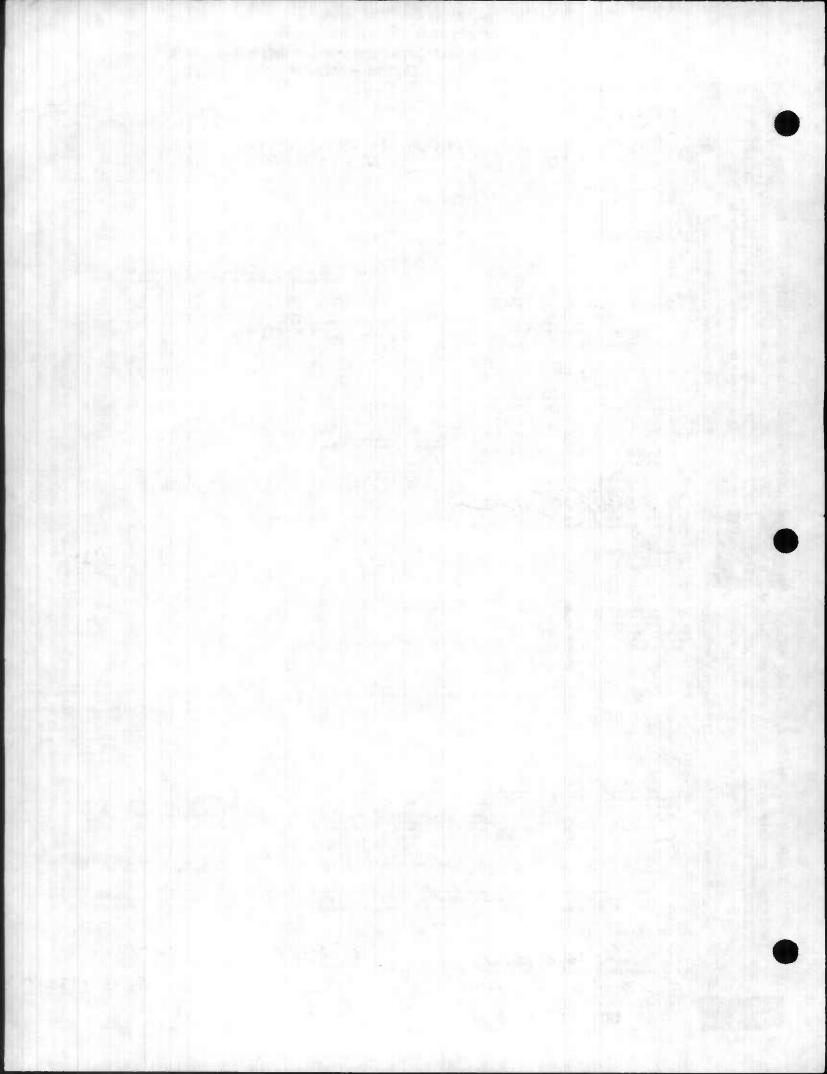
			Ce	rtificate of	Death	R	eg. No.	02110
	1. Decedent's Name (First, Middle, Last)		0	4 = 13 -		2. Oate of Deet Month		3. Time of Dec
Physician /Medical	Edward	J.	Da	wson		October	A 02	2359
Examiner	4e Fecility Name (If not institution, give str	reet end number)	1		4b. City, Town, or L	ocation of Deeth	4c. County o	Death
	Johns Hookid.	5 Unispit	41		RALLINAR	= City	Ва	Itimore City
uneral	5. Social Security Number 6. Sex	7. Age (In yrs	last birthday,	If Under 1 Year		8. Oate of Birth (Month, Day,		Birthplece (State or Fo Country)
rector	232-60-5687 X Usual Residence of Decedent	4 2□ F 62	Yrs.	Months Days	Hours Min.	Jun 12,		West Virginia
ž ti	10a. State 10b. County	10c. C	ity, Town or L	ocation				t 0d. inside City Li
To lo	Virginia Frederick C	ounty		\\/ii	nchester			1 ☐ Yes X2 ☐
be notified Director	10e. Street and Number			10f. Zip Code	ionester	1	0g. Citizen of Wi	nat Country?
2	709 Back Mountain Road				22602			J.S.A.
era lera		. Was Oecedenf Ever in U	J.S. 13.	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race	- American Indian,
"natural", or fame 23s or 28s-f show sited Examinat must be notified at leted by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Oivorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:		If Yes, specify Cub 1☐ Yes ★☐ No		Rićan, etc.)	Specify:	, White, etc. White
te a	15. Decedent's Educa		16e. Dece	dent's Usual Occu	pation		16b. Kind of Bus	iness/Industry
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E O	10			Mea	atcutter			Olocely.
Be C	17. Fether's Neme (First, Middle, Last)				18. Mother's Nam	e (First, Middle, I	Maiden Sumame)
marked other than imetic avent, tree. To Be Comp	Not Kno	wn				Geraldine	June Daw	son
THE P	t 9e. Informent's Name/Relationship (Type	, Print)	19b. Meil	ing Address (Street	t and Number or Ru	ral Route Number	City or Town, S	State, Zip Code)
27 la	Joyce A. Da				ntain Road Wi			
metho	20a. Method of Disposition	20b.	Place of Disp	osition (Neme of				City or Town, State
important: If item 27 is marked other than any injury or other traumatic avent, the bace. To Be Comp	t)☐ Burial 2 ☐ Cremation 3 ☐ Read 4 ☐ Donetion 5 ☐ Other (Specify)	noval from State		matory or other pla eadow Point	1	0/13/00	Kevser	West Virginia
injur	21. Signature of Europal Service Licenses			2. Name and Addre	Cemetery		- 10,001,	TTOST THISINIA
eny poe	JUNEAN -CH	Monis		Jones F	uneral Home.	Inc.		
	23a. Part1. Enter the disease, or complica	V			Pleasant Valle			ginia 22601 Approximate
g physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	Chronic Due to (Lymp or as a conse	ho cytic	Leuk	emía		17 year
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the a feet feet feet feet feet feet feet f	Pert ii. Other significant conditions contr	ibuting to death but not re	sulting in the	underlying cause gi	iven in Pert I.	23b. Did to	obacco uss con	tribute to the cause of de
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2 shoul						24a. Was a perform	n autopsy med?	24b. Were autopsy findi evailable prior to completion of caus of death?
page page						1 □ Y	es 2 No	1 ☐ Yes 2 ❷ No
cartificata rector, pag	25. Was cese referred to medicel				26. Place of Dea	th (Check only or	16)	
10 T	everniner?	spital:	ER/Outpatie	ent 3 DOA Ot	her:	ome 5 Reside		r (Specify)
£ @	27. Manner of Death 1 Natural 5 Pending	28a. Dete of Injury (Month, Day Year)	28b. Time of	of 28c. inju		28d. Describe h		
To the Funeral Director: After this completely filled in by the funeral Medical Certification: 1	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, s ify)			281. Location (S. City or Town		r or Rurel Route Number
plataly fillo edical C		cian: To the best of my kn r: On the besis of examin and manner steted.						
Ne Me	29b. Signature and fitle of certifie			29c. Licen	se number	2	9d. Date signed	(Month, Day, Year)
- 0	Mar. Than	um Mr		05	5-000	1	John La	- 10 2 m
6	30. Name end address of person who corr	poleted cause of death (to	m 23a\ /T	Print)	000	C	CTODE	r 10,200 aryland
		pleted ceuse of death (Ite	1	(, rint)	001 2	14.	· W	0-11-1
	Iraci hompson	Johns Ho	-	incol	ugy, De	Hmor	e, 190	iryland
State	31. Oete filed (Month, Dev Year)	32 Registrer's Sign	La Contraction of the Contractio	Some	,			



			State of Maryla			of Health a of Death	ind Men		iene) U	32	114
	Physician	1. Decedant's Name (First, Middla, La	st)		1			Date of Death Moreth	n Day	Yaar	3. Tima of Death
	/Medical	KOSEMOW)			- VI	AVIS	0	toza	. 62	7000	3:54pm
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	uneral rector	5. Social Security Number 6. S 236-70-7411	THE OWNER	not (#(5. last birthday) 72 Yrs.	If Under 1 \ Months D	rear If Under 2	MIN. FE	Data of Birth	Year) 1928	9. Birthpla Country	ce (Stata or Foraign
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arytan	d at	10a. Steta 10b. County	10c. C	City, Town or Lo	cation timore					10	d. Inside City Limits 1 X Yas 2 □ No
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death with the Maryland	r tems 23s or 28s-f- ning most be notified Funeral Director	11. Maritel Stetus	12. Was Decedent Evar in I	U,S. 13.	Was Deceden	t of Hispenic Orig Cuban, Maxican,	in? (Specify	Yes or No-		USA e - America	
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⊆ 8 <u>a</u>	Be en	17. Fathar's Nama (First, Middle, Last) George H. Spears					rs Nama (Fii Lieha		faidan Suman	7a)	
laryla 2 should and Men	marked imatic e	19a. Informant's Name/Ralationship (Type, Print)	19b. Maili	ng Addrass (S	traat and Number				Stata, Zip (Coda)
Mand 2 salth ar	r treu	Alice Hendrix/sis				rward AV		ltimor		21218	
Baltimore, N	nt: If item 27 is marks by or other treumatic To	20a. Mathod of Disposition 1 □ Burlel 2 □ Cremetion 3 □ 4 □ Donation 5 ☒ Other (Specif	Removal from Stete	Place of Dispo camatary, crai	sition (Nama natory or othe	of r place)	I D	eta 2	20c. Location	City or Tow	m, State
Balti Permit.	important any injury ansa	21. Signature of Funetal Service Licer Ronald S.				Addrass of Facility Anatomy	Board 21201		N. Balt	imore	Street
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Becutad	n and ial-transit Examine	Sequentially list conditions,	b. Dua to ((or as a consec	juance of):						
68760,	ysicia ne bur	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	C. Dua to (or as a consec	uance of):			7914			
Box 6	for use as the cian/Med		d								
P.O.	yaic yaic	Part II. Other eignificant conditions of	contributing to death but not re	sulting in tha u	nderlying caus	sa givan in Part I.		23b. Did to	bacco use co	ntribute to	the ceuse of death?
	s signed by the attending id be detached for use a d by Physician/M	HYPERTENSI	SW S						90 2□No	3 Prob	ably Unknown
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Division t or Attending after death.	at Director: After the in by the funeral certification:	1 Natural 5 Panding Investigation 3 Suicide 6 Could not b datarmined	e 28a. Place of Injury - At I	Injury homa, farm, str	М	1 Yas 2 1		Location (St	raat and Num	ber or Rural	Routa Number,
DIV pital or A	filled in:	4 Homicida 29a. Cartifiar Cartifying Ph	building, atc. (Special Special	occurred at t	ha tima data and	d place and	City or Town		annar es stu	ated	
To the Hospital	To the Funeral I completely filled Medical Ce	(Check only 2 Medical Examone)	niner: On the basis of axamin and mannar stated.	ation and/or in	vastigation, in	my opinion, daat	th occurred a	t tha tima, da	ata and placa,	and dua to	tha causa(s)
Toth	To the Funeral of completely Illed Medical Ce	29b. Signatura and titla of certifier	0		29c. L	icansa number			9d. Date signe		
		30. Name and address of person who	completed cause of heath (fre	m 23a) (Type	Print)	2868	7		10/0	4/00	urry
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Registrar

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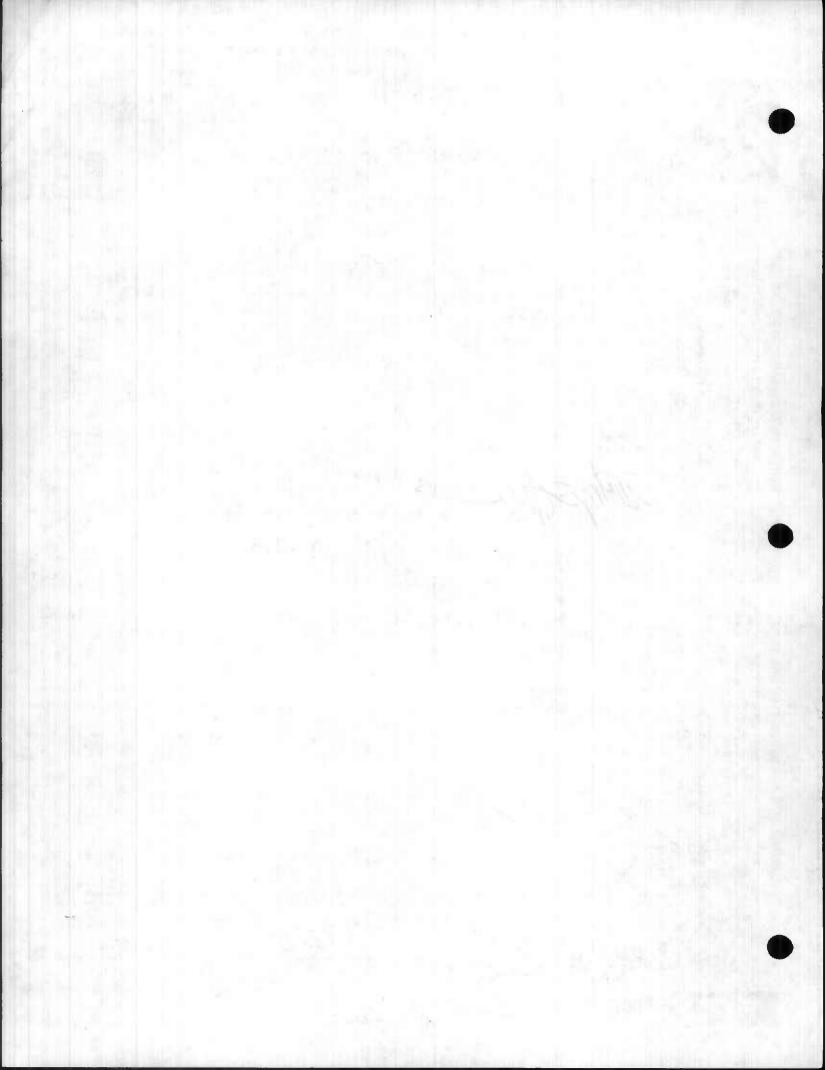


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death DIPIETRO 10:10 PM **Physician** RICHARD 05 0 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Columbia Howard Howard County General Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplaca (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** X□M 2□F Months Days Houra 65 Yrs. Director 212-30-8976 Feb 25, 1935 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shor traumatic avant, the Medical Examinar must be notified at 1 Yas X2 No Director Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 U.S.A. 11020 Hidden Fox Court Funeral 12. Was Decedent Ever in U,S. Armed Forces? Waa Decedent of Hispanic Origin? (Specify Yea or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1953 Baltimore, Maryland 21215-0020 "natural", or White þ 3 ☐ Widowed 4 ☐ Divorced 1956 Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent'a Education (Specify only highest grade completed) filed within 7.

Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Automotive General Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be 2 should be f end Mental I Helen Rose Capo Primo DiPietro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 sh Department of Health end Important: If Itam 27 Ia m any Injury or other traun 11020 Hidden Fox Court Ellicott City, Maryland 21042 Ms. Marilyn L. DiPietro 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a Method of Disposition 20c. Location - City or Town, Stata tX□ Burial 2 □ Cremation 3 □ Removal from State 10/10/00 Clarksville, Maryland Columbia Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Slack Funeral Home, P.A. MOIII3 3871 Old Columbia Pike Ellicott City, MD 21043 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Approximata Interval Between Onset and Death **Physician** ASPIRATION PNEW MONIA 10 DAY 1 Immediate Cause (Final disease or condition resulting in death) /Medical Examiner NTESTING ILEUS Examin the bunial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last COLON CARCINOMA IYEAR Box 68760 Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. CHRONIL OBSTRUCTIVE PULMONARY DISEASE 2 2□ No 3 Probably 4 Unknown py 24b. Were autopsy tindings available prior to completion of cause ot death? 24a. Was an autopsy performed? Completed has 1 ☐ Yes 2 ☐ No certificate al or Attending Physician: T s after death. I Director: After this certifical 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yea 2 No 2 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident invastigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and I 29d. Date signed (Month, Day, Year) 010622000 who completed cause of death (Item 23a) (Type, Print)

LMD 2465 RT- 97 SUITK 10 SCOTT MANRER MO GLEN WOUD MD 2 1 2 2000 32, Registrar'a Signature Registra



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $\,\cup\,\cup\,$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month 200 30 fm ei 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) al tax Dox N/A Ta If Under 24 Hrs. If Under 1 5. Social Security Number Sex ∬ 1 M 2 F 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Days 67 Yrs. 219-32-7055 04/30/1933 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 2779 Yarnall Road 21227 United States 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. Black, Whita, atc. 1 Tyas 2 No If Yes, Give 2/16/53 Yaar or Detes: 2/16/56 1 ☐ Nevar Marriad 2 ☑ Married 1 ☐ Yas 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Automotive 6 Mechanic 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maidan Sumama) Virginia Daughty Howard Chester Lawrence Durm, Sr. 19e, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 2779 Yarnall Rd. Baltimore, MD. 21227 Cora Lorraine Durm 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Buriel 2 ☐ Cremation 3 ☐ Removal from State 10/13/00 Brooklyn Park, MD. Cedar Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility Ambrose Funeral Home, INC. 1328 Sulphur Spring RD. Arbutus, Maryland 21227 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Dua to (or as a consequence of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert f. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown bstructive (muy 1) ric Cardioviscular 24b. Were eutopsy findings available prior to 24a. Was an autopsy completion of causa of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 BER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Date of tnjury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Neturat 1 Yes 2 No 2 Accident 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie

Physician /Medical Examiner Completed by Physician/Medical Examiner burial-tran and Box 68760.

Physician

/Medical

Examiner

Funeral

Director

Items 23a or 28a-f ahow

Director

Funeral

Completed by

Be

avant, the Medical Examiner must be notified at

"natural", or

al Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flam 27 is marked oth any injury or other traumatic avant PAGE.

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0020

The law requires that the death certificate be executed signed by the attanding physician to be detached for usa as the buria of Vital Records, P.O. After this certificate has septat or Attanding Physician: Thours after death.
Ineral Director: After this certificat if filled in by the funeral director, put Division To the Hospital within 24 hours a To the Funeral Completely filled

> State Registrar

DHMH 16 Rev 6/95

Certification: To Be

Medical

(Check only one)

29b. Signature and fitte of certifier

address of parson who completed ceuse of death (Item 23a) (Typa, Print)

Necillo WO. 31. Date (jed (Month, Day, Year) 32. Registrar's Signature

Deneva

4000 Annapolis Rd Baltimore Mrs 21227

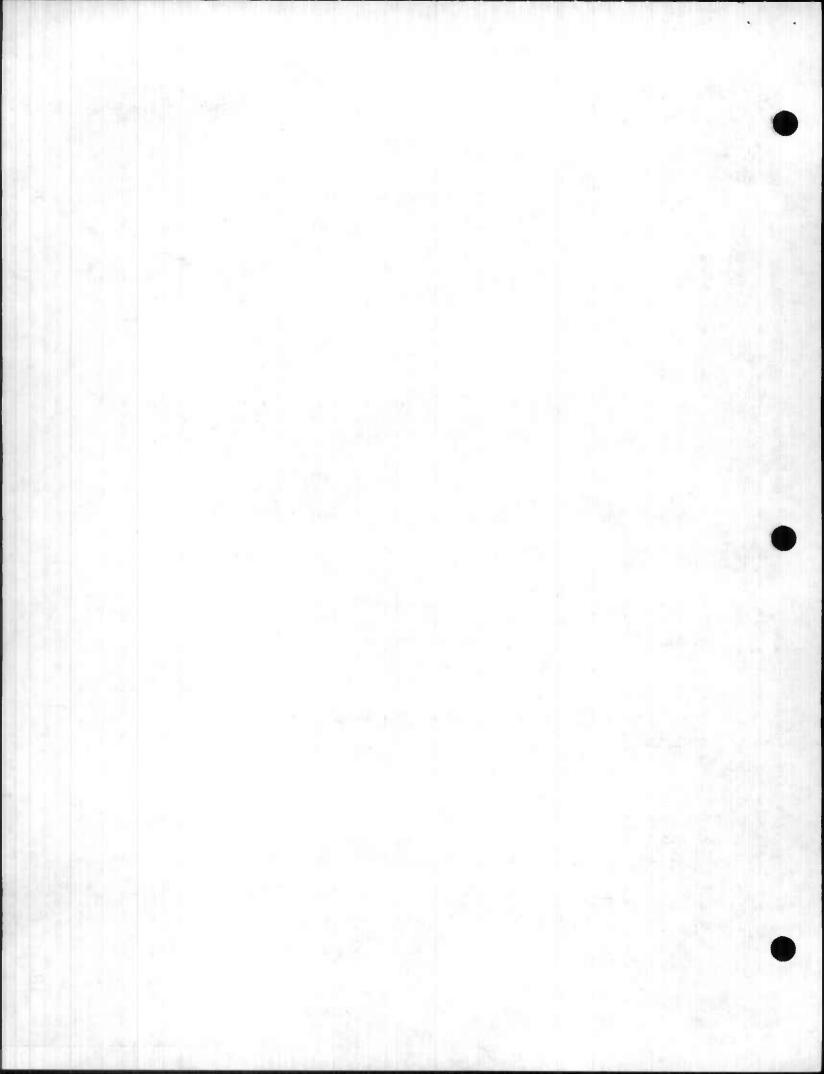
29c. License number

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29d. Date signed (Month, Dey, Year)

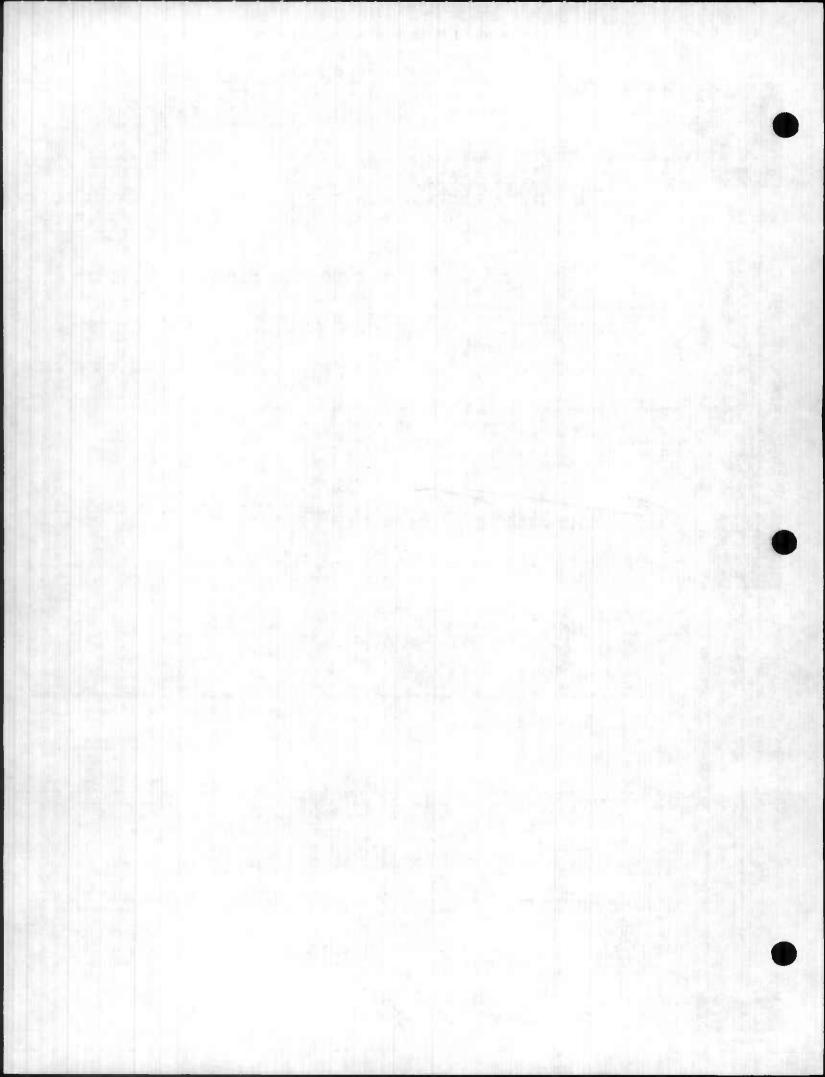
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 2 1

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State of Maryland / Department of Health and Mental Hygiene

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popula	Funeral pletely filled edical C	29a. Certifier 1 Certify (Check only one) 1 Medica	ng Physician: To the Examiner: On the and ma	ne best of my know basis of examinat nner steted.	wledge, deel tion and/or in	th occurred at the	ne time my opi	e, date ar inlon, dee	nd place, oth occur	and due to the red at the time,	cause(s) and m dete end place	nanner as s , and due t	stated. the cause(s)
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4	33	30. Name and address of person	who completed car				t,	Balt	imor	e, Mary	land 21	201	456
	State Registrar	31. Date filed (Month, Day, Year OCT 1 2 2000		Registrar's Sign	pure Ag	souls							ы



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Dayton **Physician** Florence Μ. 10, 2000 9:05 AM Oct. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Wicomico Salisbury Center; Genesis ElderCare salisbury, Md. If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar Birthplaca (Stata or Foraign Country) **Funeral** 1 M WXF Months Days 058-09-3348 Director March 15, 1906 Brooklyn, Usual Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits or harris 23a or 28a-f show MD Wicomico Salisbury Maryland Yas 2 No Director the Medical Examiner must be notified 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 100 East Carroll Street 21801 United States Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yes 2 X No If Yas, Giva Year or Datas: 1 □ Nevar Married 2 □ Married 21215-0020 1 ☐ Yas 2 ☒ No Specify: Specify: White à 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b Kind of Business/Industry should be filed within al Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Clerk Unk. Insurance Unk. Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) and Mental Douglas Cunningham Caroline Cudlipp 19e. Informant's Name/Relationship (Type, Print) 19b. Meiting Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) .89 Pages 1 and 2 21801 Adrienne Waring / Niece 7516 Titleist Drive, Salisbury Maryland Department of Health Important: If Item 27 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 🖾 Ramoval from Stata Evergreen Cemetery, October 13, 2000 Brooklyn, 4 ☐ Donatton 5 ☐ Other (Specify) 21. Sphalus of Eunaral Sarvice Licensee Victor P. Doda, Jr. 22. Nama and Addrass of Facility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Aveneu, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset end Death **Physician** llenstuking Immediate Ceuse (Final diseasa or condition rasulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Entar Undarlying Causa (Diseasa or injury that initiated avants rasulting to death) Last Box 68760. Dua to (or as a consequence of): P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown signed by by Records, 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed Horano leg aleens After this certificate has 1 Yas 2 No 1 Yas 2 No of Vital lat or Attending Physicien: The after death.

It after the contilicat of the funeral director, property of the funeral director, property of the funeral director, property of the funeral director, property of the funeral director, property of the funeral director, property of the funeral director, property of the funeral director, property of the funeral director, property of the funeral director, property of the funeral director, property of the funeral director, property of the funeral director, property of the funeral director, property of the funeral director of the funer 25. Was casa rafarred to medicat 26. Placa of Deeth (Chack only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) Medical Certification: To 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 28b. Time of 27. Menner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred Division 1- Natural 5 Panding invastigation 1 Yas 2 No 2 Accidant 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifier 29b. Signatura and title of certifier 29d. Data signad (Month, Day, Year) 29c. Licansa number 39813 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

Registrar

State

MICHAEL ATKINS, M.D.,

31. Data filed (Month, Day, Year)

MAY DAYTON

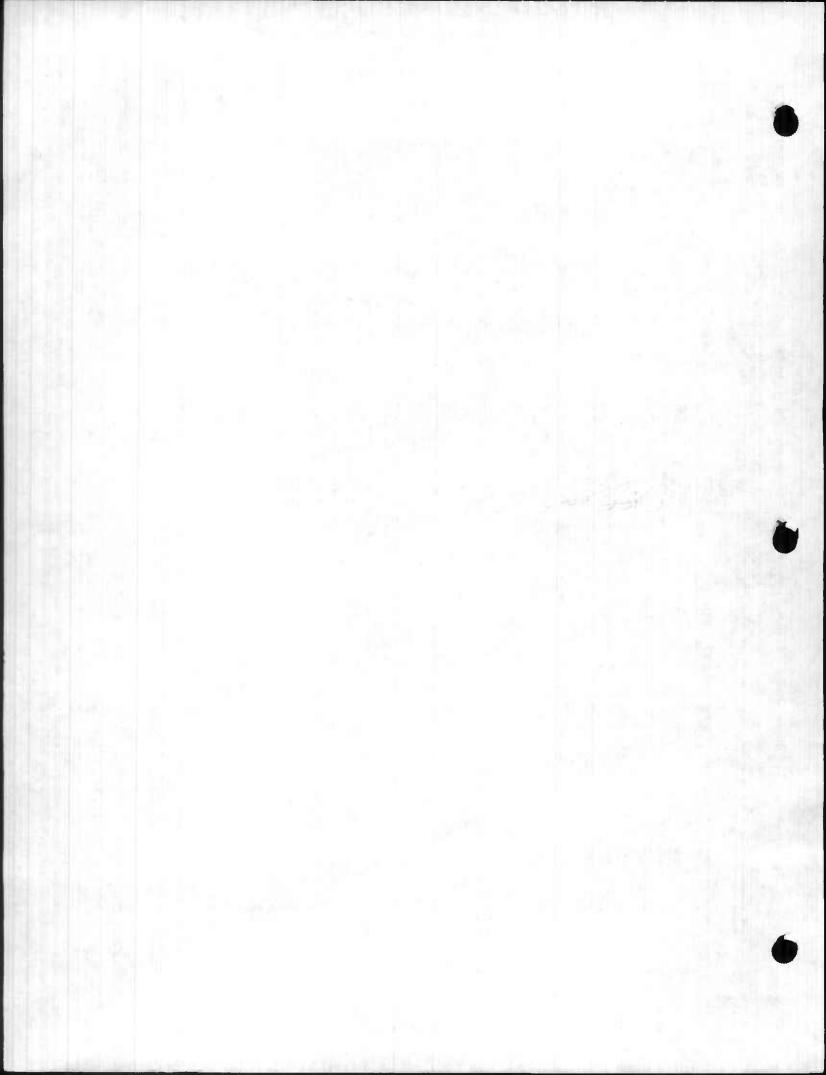
ORENCE

32. Ragistrar's Signatura

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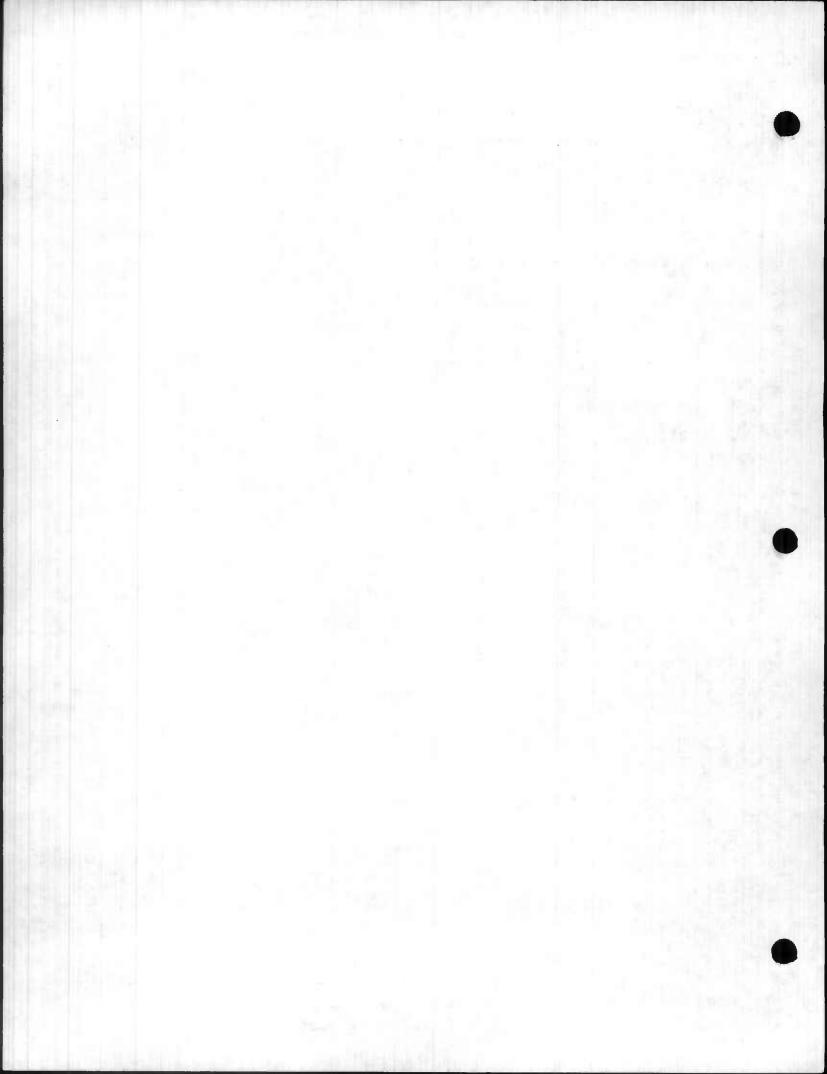
1104 HEALTHWAY DR., SALISBURY, MD

21804



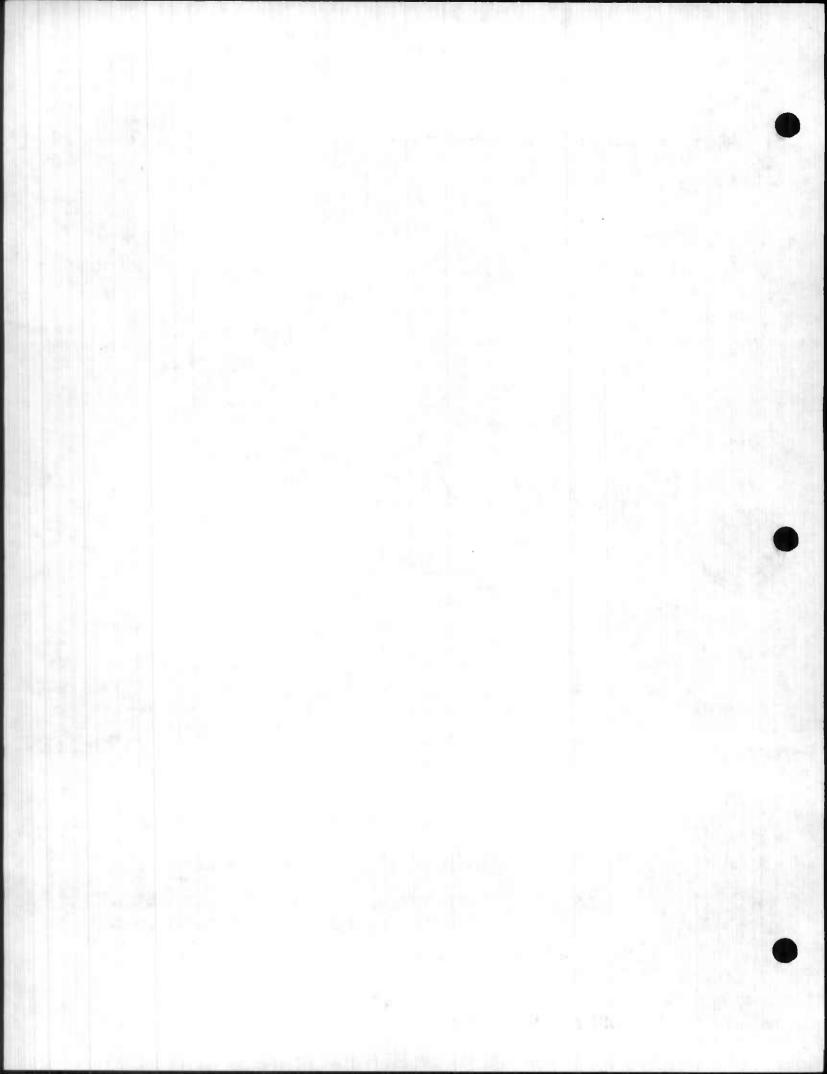
State of Maryland / Department of Health and Mental Hygiene 0 32120

ique		Certif	ificate o	Doutin		Reg. No.		
1. Decedent's Name (First, Middle, Last)				2. Date of D	Day	Year	3. Time of Death
Jennifer Lorena Ech	nenique				Octobe		2000	8:30 P.M.
4a Facility Name (If not institution, give	street and number)				or Location of Dea	ath 4c. Co	ounty of Deat	th
University of Mar			M Hadar 1 Va	Baltin			N/A	
5. Social Security Number 6. Se 123-29-0825	7. Age (In yrs		If Under 1 Ye Months Day		lin. (Month, L	Day, Year) 2,1981	9. Birt Co Hone	thplace (State or Foreig ountry) duras
Usual Residence of Decedent								
10a. State 10b. County	Back Street	ity, Town or Locat	ition					10d. Inside City Limits
MD. Prince Ge	eorge Lau							1 Yes 2 No
10e. Street and Number			10f. Zip Cod	е		10g. Citizer	n of What Co	untry?
13008 Old Stage Co			20708		10 11 11	Hondur	as (gr	een card)
11. Merital Stafus 1 → Never Married 2 → Married 3 → Widowed 4 → Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:	13. Wa	Yes 2 1	of Hispanic Origin? Suban, Mexican, Pu No <i>Specify:</i> HO	(Specify Yes or refer of Rican, etc.)		Black, Whit	te, etc.
15. Decedent's Edu		16a Deceden	nt's Usual Oca	cupation		16b. Kind	of Business/	/Industry
(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give kin life. DO	nd of work do	ne during most of tired)	working			
12	Conego (1 401 34)	Clerk				Auto	Insura	ance
17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Midd			
Gustavo A. Echenic	lue			Patric	ia Valle			
19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Mailing	Address (Stre	eet and Number or	Rural Route Num	ber, City or T	own, State,	Zip Code)
Gustavo A. Echenic 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State Ga	Place of Dispositi cemetery, cremat tes of H	ion (Name of tory or other)	place)	October1	20c. Loca Silv	tion - City or er Spi	yland20708 Town, State ring, Mary
234 Part. Enter the displace, or compositors, or heart failure. List only o	ications that caused the deane cause on each line.	ath. Do not enter t	T Sand the mode of	ly Spring dying, such as care	Road, L diac or respiratory	aurel, arrest,	Maryl	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	Adult Res Due to (Due to (spiratory (or as a conseque nock (or as a conseque	y Dist		1			Onset and Death
grook of heart talure. List only of	Adult Res Due to (Renal Fai Due to (Due to (spiratory (or as a conseque nock (or as a conseque lure or es a conseque	y Dist	ress Synd	1	aurel,		Onset and Death
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Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions condi	Adult Res Due to (Septic Sh. Due to (Renal Fai Due to (Multiple d. Hospital: 1X Inpatient 2E 28a. Date of Injury (Month, Day Year)	or as a consequence of as a consequence or as	y Dist	ress Syncouries 26. Place of Other: 4 Nursin Injury at Work?	23b. Di 24a. W. Pe Appri Death (Check only 28d. Describ the. di	d tobacco us Yes 25 es an autopsy rformed? COVa1 Yes 25 y one) sidenca 6 [e how injury of	ne contribute No 3 P 24b.	e to the cause of death were eutopsy findings eveilable prior to completion of cause of death? I Yes 2 No
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State of Maryland / Department of Health and Mental Hygiene 00 22121

			Ce	rtificate	of L	Death		8	Reg. No.	0 0		1.
	1. Decedent's Nama (First, Middle, L	ast)					2	2. Data of Dea Month	th Day	Year	3. Time of	Death
/sician ledical	ANDREW G.	ESER						October		000	2:44	A.M.
iner	4a Facility Nama (If not institution, g				4	b. City, Tov	wn, or Loca	ation of Death	4c. County			
	University of Ma	gs.					imore			N/A		
	5. Social Sacurity Number 6. 213–29–3890	Sex 7. Age	(In yrs. last birthday, 18 Yrs.	Months	Yaar Days	If Under 2 Hours	Min.	B. Data of Birth (Month, Dey Aug. 1	7. Year) 2 1982	9. Birthple Count Ohio		Foreign
	Usual Rasidence of Decedent 10e. Stata 10b. County		10c. City, Town or L	ocation	-					10	d. fnsida Cit	u Limite
>		rundel Co.	Toc. City, Town of E	Pasa	don:	2					1 Yas	
Director	10e. Street and Number	runcer co.		10f, Zip C		u	_		10g. Citizan of	What Count		Λ
al Dir	1903 Orchard Po	int Road		101, 2ip 0		21122	36			USA	.,,	
by Funeral	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant E Armed Forcas? 1 ☐ Yas 2 ☒ N If Yas, Giva Yaar or Datas:		Was Deceda If Yas, specify 1 ☐ Yas 2		ispanic Orig nn, Maxican Specify:	gin? (Spec , Puarto R	ify Yas or No- ican, atc.)	Bla	ca - Amarica ck, Whita, a y: Whit	itc.	
Completed	15. Decedent's (Specify only highast g	Education erade completed)	(Give	dent's Usual	done d	during most	of working	,	16b. Kind of B	usiness/Ind	ustry	
idu	Elamentary/Secondary (0-12)	College (1-4or 5	+)	<i>bo Not</i> use dent	retired	0			Educat	ion		
	17. Fathar's Nama (First, Middle, Lat		bcu	uenc		18. Motha	r's Nama	(First, Middle,	Maiden Suman	n <i>e)</i>		
o Be	Karl R. Eser	1 700				Line	da S.	Beadl	e			
-	19a. Informant's Name/Ralationship					an <i>d N</i> um <i>be</i>	or or Rural	Routa Numbe	or, City or Town			
	Karl and Linda E	ser (Paren	its) 190	3 Orch	ard	Poin	t Roa	d, Pas	adena,	Md. 2	1122	
	20a. Method of Disposition 1 Durial 2 Cramation 3	☐Ramoval from Stata	100000000000000000000000000000000000000	matory or oth	er plac			Data	20c. Location	- 1		
	4 Donation 5 DOthar (Spec		Mt. Carm	nel Cem	ete	ery 1	0/16	/2000	Pasade	na, Mo	d.	
once.	21. Signatura of Funerel Sarvice Lig	2000	() 2	2. Nama and				Funora	1 Home	Dλ		
a	men &	Janu.		3204	Mo	untai	n Roa	d. Pas	adena.		1122	
	233 Part1. Entar tha disaase, or co hock, or haart failura. List on	mproations that caused by one cause on each lin	tha daath. Do not an	itar tha moda	of dyin	g, such as	cardiac or	raspiratory ar	rast,		Approximate fntarval Baty	veen
in 💮											Onsat and D	Daath
al er	Immediata Causa (Final disaasa or condition	Multip	le Injurie	es								
100	resulting in deeth)	a	Due to (or es a conse	quenca of):								
line		b										
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Disease or Injury		Dua to (or as a conse	quanca of):								
	Cause. Enter Undarlying Ceuse (Disease or Injury that initiated evants	С										
Medical	rasulting in death) Last		Dua to (or as a conse	quanca or):								
Physician/	Part II. Other significant conditions	contributing to death bu	t not resulting in the	undarlying car	viv sea	an in Part I		23b. Dld t	obacco uae co	entribute to	the cause o	of death?
	Tarri. Other algimount conditions	contributing to doubt bu	thot tasuling in that	origanying out	ou giv	an			Yes 2 No			
d by								24a. Was	an autopsy	24b. Wa	ara autopsy f ailabla prior to	indings
Completed							_	perfo	med?	cor	ailabla prior to aplation of co death?	o ausa
ошо								181	ras 2□No		Yas 2	No
Ü	25. Was casa rafarred to medical					26 Diaco	of Death	(Check only o				
To Be	axaminar? X☐ Yas 2☐ No	Hospital:	nt 2 ER/Outpatie	ant 3 DOA	Oth	er.			danca 6 🗆 Oti	har (Snecifi	/}	
-	27. Menner of Death	28a. Date of Injur (Month, Day			c. Injur		-		now injury occu		ver o	f
C	1 ☐ Netural 5 ☐ Pending invastigat			PM		Yes 2			involv	ved in	vehic	cular
ation		28a. Placa of Inju- building, ato	ry - At homa, farm, s	treat, factory,	offica		21	Bf. Location (S	Street and Num vn, Stete) Mag	ber or Rura	Poute Num	ber,
ification	3 ☐ Suicida 6 ☐ Could not detarmine	building, atc	Ro	padway			n	ear Meti	spa Dr.	Sevema	Park,	MD
Sertification	3 Suicida 6 Could not 4 Homicide detarmine											
ilcal Certification	4 Homicide 29a. Cartifiar (Check only (Ch	Physician: To the best of aminer: On the basis of	axamination and/or it	th occurred at nvastigation, i	tha tin	na, data an pinion, daa	th occurre	d at tha tima,	dete end piece,	, and dua lo	tha causa(s)
Medical Certification:	4 Homicide 29a. Cartifiar (Check only one) 1 Certifying I	Physician: To the best of	axamination and/or it	nvastigation, i	n my o	pinion, daa	th occurre	d at tha tima,	dete end plece	, and dua lo	tha causa(s)
Medical Certification	4 Homicide 29a. Cartifiar (Check only (Ch	Physician: To the best of aminer: On the basis of	axamination and/or it	nvastigation, i	n my o	pinion, daa a number	th occurred	d at tha tima,	dete end plece, 29d. Data sign:	, and dua lo ad (Month, I	tha causa(s Day, Year))
Medical Certification	29a. Cartifiar (Check only one) 29b. Signature and 19h of certifiar	Physician: To the best of aminer: On the basis of and manner sta	axamination and/or in	29c.	n my o	pinion, daa	th occurred	d at tha tima,	dete end plece	, and dua lo ad (Month, I	tha causa(s Day, Year))
Completely filled in by the fune Medical Certification	4 Homicide 29a. Cartifiar (Check only one) 1 Certifying I	Physician: To the best of arminer: On the basis of and manner sta	axamination and/or in	29c.	Licans	a number	I.E.	d at tha tima,	dete end plece, 29d. Data sign:	and dua lo	Day, Year))



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iend Teell
Physician /Medical Examiner
F-Market 1

Mary JoAnn Edmondson 4a Facility Nema (If not institution, give street and number) 1146 GLORIA AVENUE

5. Social Security Number

218-36-9377

4b. City, Town, or Location of Death Baltimore

2. Data of Death 3. Time of Death Month Day SEPTEMBER 30, 2000 22:32 PM

4c. County of Death BALTIMORE

Director

Usual Residence of Decedent 10a. State

1. Decedent's Neme (First, Middle, Last)

10c. City, Town or Location

Yrs

If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) February 8,1939 Maryland

Birthplaca (State or Foraign
Country)

the Medical Examiner must be notif

"natural", or items 23a or

72 hours after

filed within

Saltimore, Maryland 21215-0020

Directo

Funeral

þ

Completed

Maryland Baltimore Baltimore

7. Aga (In yrs. last birthday)

61

t 0d. Insida City Limits t ☐ Yas 2 No

10e. Street and Number

1146 Gloria Avenue

t□M 20 F

21227

10f. Zip Code

10g. Citizen of What Country? United States

t t. Maritat Status

1 Nevar Married 2 Married 3 ☐ Widowed 4 ☑ Divorced

t2. Wes Decedent Ever in U,S. Armed Forces? t Yas 2 No If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No tt Yas, specify Cuben, Mexican, Puerto Rican, etc.) t ☐ Yes 2K No Specify.

14. Rece - American Indian, Black, White, etc. White Specify

t 5. Decedant's Education (Specify only highest grade completed)

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementery/Secondery (0-12) 12

College (t-4or 5+) Clerical Westinghouse

17. Fathar's Name (First, Middla, Last)

Joseph Bawroski

Doris Stierhoff

18. Mother's Name (First, Middle, Maiden Sumame)

t9a. Informant's Name/Relationship (Type, Print)

t 9b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 619 Carl Avenue, Glen Burnie, Maryland 21060

Marcie Smith/Daughter

21. Signature of Furniral Service Connu

20b. Place of Disposition (Nema of cemetery, cremetory or other piece)

Dete 20c. Location - City or Town, State

20e. Method of Disposition

t Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

Loudon Park Cemetery 22. Name end Address of Facility

10-5-00 Baltimore, Maryland Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229

permit. Pages 1 and 2 should be file.
Department of health and Mental Hyg.
Important: If them 27 is marked any Injury or other to any Inj **Physician** /Medical Examiner

attanding physicien end for use as the burial-tran

detached the

ate has been signed by page 2 should be detact

this

After s after deen.

filled in

completely

within 24 hours a

2

The law requires that the death certificate be axecuted

P.O. Box 68760,

Division of Vital Records,

or Attending Physician:

Physician/Medical Examine

þ

Completed

Be

10

Certification:

Medical

Immediete Cause (Final disease or condition resulting in death)

PROPOXYPHENE INTOXICATION

23a. Rarft. Erner the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of):

Due to (or es a consequence of)

Due to (or as a consequence of)

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated avents resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MESOTHELIOMA OF LUNG

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes en eutopsy performed?

24b. Were eutopsy tindings evailable prior to completion of ceuse of deeth?

Approximete Onsat and Death

1 Yes 2 No

Arbutus, Maryland

t ☐ Yes 25 No

25. Wes cese reterred to medical t Yes 2□ No

27. Menner of Deeth

5 Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of founday 9/30/00

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 28c. Injury at Work? t ☐ Yes 2 No 10:25

26. Place of Death (Check only one)

28d. Describe how injury occurred subject took drug overdose 28f. Location (Street and Number of Rural Route Number, City or Town, State) 1146 Gloria Avenue

29e. Certifier

t Neturel

2 Accident

3 X Suicide

4 - Homicide

t Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and plece, end due to the cause(s) end manner stated. 29b. Signature and title of certities

residence

29c. License number OCME

29d. Date signed (Month, Dey, Year) OCTOBER 01, 2000

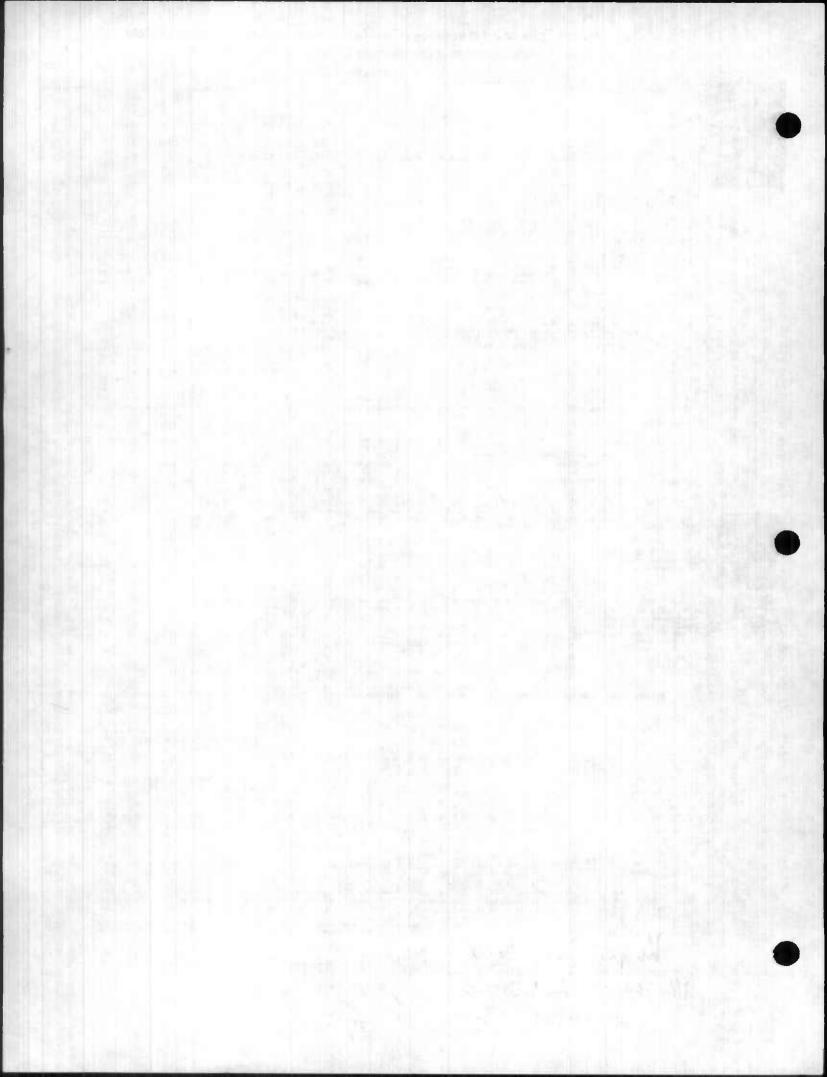
me 30. Neme end address of person who completed cause of death (Item 23e) (Type, Print)

1 2 2000

MAGGARION 3t. Date filed (Month, Dey, Year) DROW 32. Registrer's Signature

111 Penn Street, Baltimore, Maryland 21201 Muchanis

State Registrar



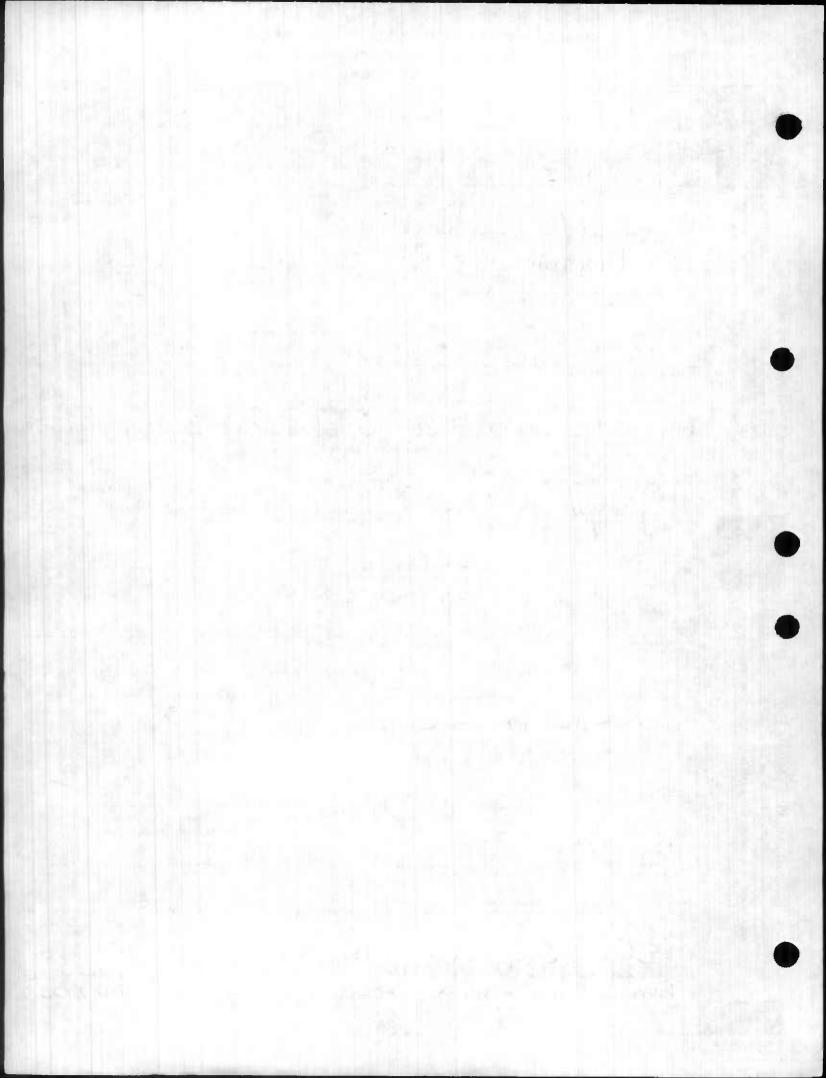
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU AMEND ITEM: 20B -20C PER F.H. G789 11-29-00 WR. Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month 05:40 **Physician** armer WAde 10 08 00 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deat **Examiner** DU nore If Under 24 Hrs. 8. Date of Birth lace (State or Foreign 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min 39-22 1 M 2 F Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or flame 23a or 28a-f ahow traumatic event, the Medical Examinar mast be notified at 1 Yes 2 No Directo Maryland mor 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral ninada Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11 Marital Status 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1□ Yes 2□XNo Specify by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. ondery (0-12) College (1-4or 5+) Elementary/Sec permit. Pages 1 and 2 should be filt Department of Health and Mentel Hy Important: if Item 27 is marked oth any liqury or other traumatic event place. 17. Father's Name (First, Middle, Last) Baltimore, Maryland 19a. Informant's Name/Aplationship (Type Print) (niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md. 21 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TO/19/00 LANSDOWNE, MD MT. ZION unk 22. Name and Address of Facility 21. Signature of Funeral Service Litenses Joseph 22221 5a Home Md.21216 W. North HVe. eye, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final PSL diseese or condition resulting in death) Examiner Due to (or as e consequence of): Physician/Medical Examiner 1 mon that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as e consequence of): Division of Vital Records, P.O. Box 687 Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ or Attending Physician: The law requires 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24a. Was en autopsy Be Completed performed' cate hes t 1 ☐ Yes 2☐ No 1 Yes this certificate 25. Was cese referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpetient 3 DOA 1 Inpatient 27. Manner of Death 1 Natural 28d. Describe how Injury occurred 28b. Time of tnjury at Work? After 5 Pending investigation within 24 hours after death.
To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Hospita Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who complete use of death (Item 23a) (Type, Print) WEST BALTIMORE BONSECON HOSP 1790 2000 31. Date filed (Month, Day, Year)
OCT 1 2 2000

DHMH 16 Rev 6/95

State Registrar

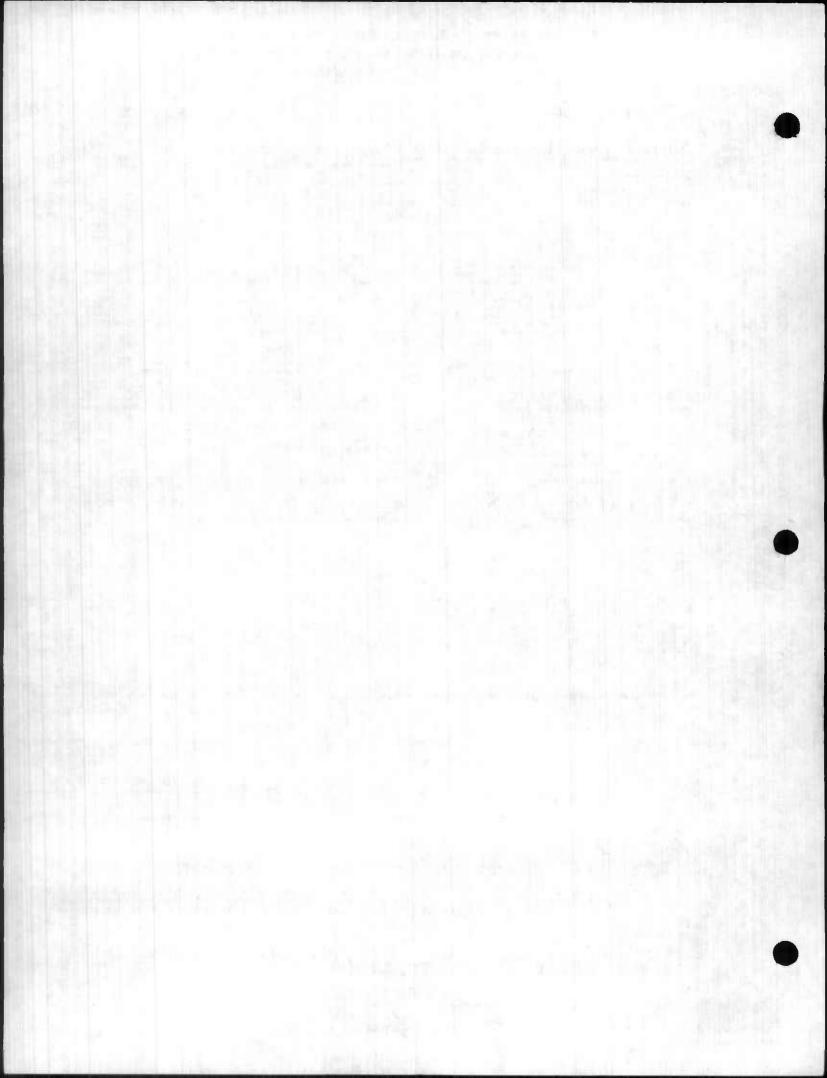
32. Registrar's Signatur



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 32 | 2 |

	Certificate of Death	Reg	, No.							
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Physician	Fl Felder Se	10	Day Yaar	9:15Am						
/Medical Examiner	4a Facility Name (If not institution, give street end number) 4b. City, Town, or Lo	ocation of Death	4c. County of Des	ith						
L LAGITIMET	Johns Honkins Barriew Medical Center Baltin	nore	Balt	imare						
Funeral	5. Social Security Number 6. Sax 7, Age (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs.	8. Data of Birth (Month, Dey, Y		thplaca (State or Foreign ountry)						
Director	247-20-2939 X M 20 F 83 Yrs. Months Days Hours Min.	11-25-	16	SC SC						
	Usual Residence of Decedent									
A STATE OF THE	10a. Stata 10b. County 10c. City, Town or Location		-	10d. Inside City Limits						
Mar Had tor	MD NA Baltimore		1 Ves 2□							
with the Ma t or 28a-f s be notified Director	10e. Street and Number 10f. Zip Code	. Citizen of Whet C	ountry?							
	102 W 2044 Gharah	N - 10	****							
her death v r heme 23 diner must Funeral	123 W. 29th Street 21218 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	ify Yes or No- 14. Raca - American Indian,							
The fine	Armed Forcas? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Rican, etc.) Black, White, etc.							
by B	If Yes, Give 1 ☐ Yas 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: Black							
Pd attended	15. Decedent's Education 16a. Decedent's Usual Occupation	16	Sb. Kind of Business	/Industry						
Ind 21215-0 be flad within 72 ho is! Hyglene. d other than 'natur event, the Medical. Be Completed	(Specify only highest grede completed) (Give kind of work done during most of work	ing								
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Maryland 21215-0020 5 2 should be filed within 72 hours at the and Mental Hygere. 7 is restrict other than "natural", or traumetic event, the Medical Exam To Be Completed by I	Lawrence Felder Emma		ackwood							
Aar and and and and and	19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Run									
CHNY	Ed Felder, Jr. 1545 Wadworth Way									
altimore, mit. Pages 1 a partment of Hei portant: Il Item f injury or othe	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other placa)	Data 20	Oc. Location - City or	Town, Stata MD						
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and and and and and and and and and and				and 21202						
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	WM.C.March FH 1:									
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Division of Vital Records, or Attending Physician: The law requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be extification: To Be Completed by			a 5 Residence 6 Other (Specify) d. Describe how injury occurred							
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Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	29b. Signature and title of certifier 29c. License number	29d. Data signed (Month, Dey, Year)								
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h 3+1	30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)		111							
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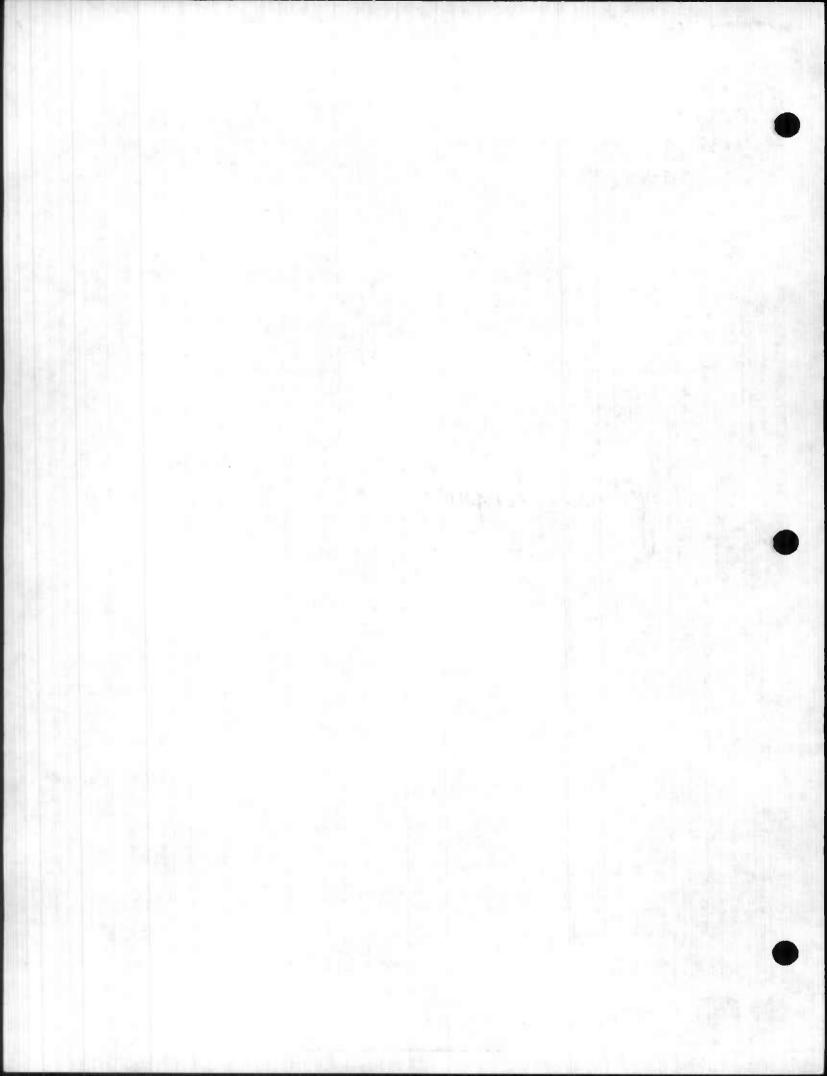


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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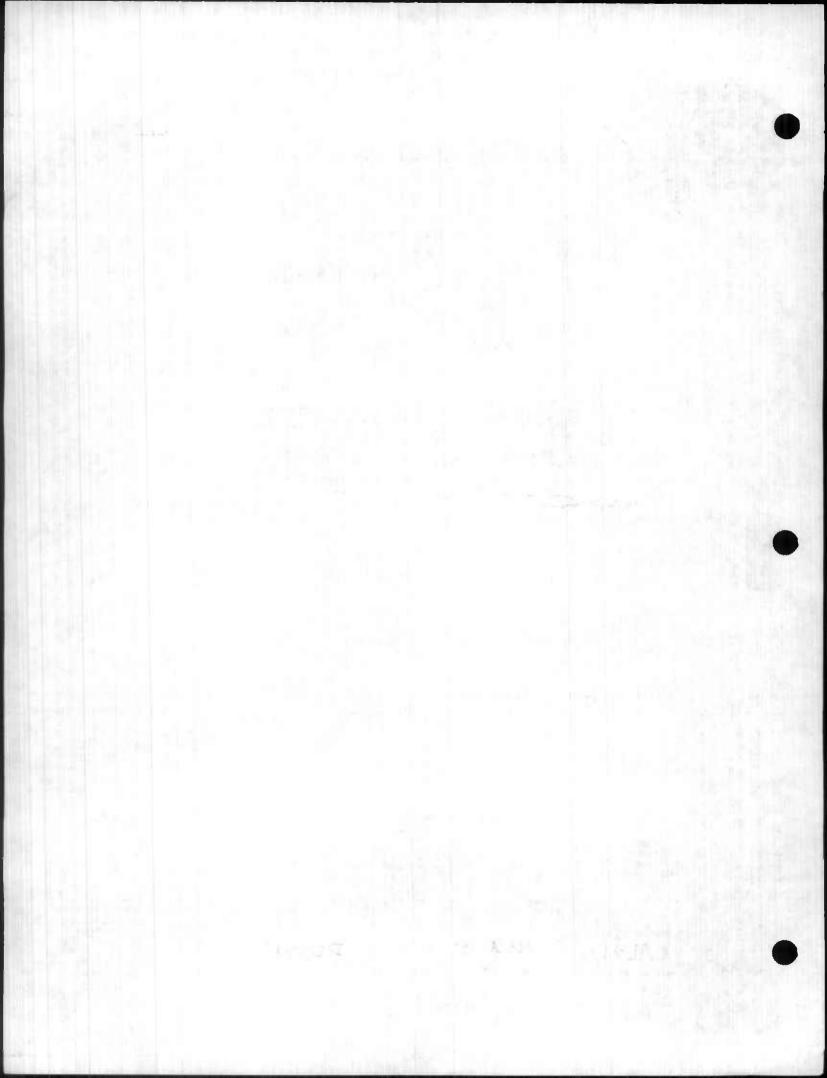
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/Med					4b. City, Town, or Lo	CATORE	4c. County	2000 5:15 AM			
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		Saint Joseph Med			Towso			Baltimore			
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hoop in hoop	edical	29a. Certifier 1 ☐ Certifying Physician: (Check only 2 ☐ Medical Examiner: On	To the best of my knowledga, da tha basis of axamination and/or	ath occurred at that invastigation, in my	tima, data and place, opinion, daath occur	and dua to tha cred at tha tima, c	causa(s) and ma data and place, a	nnar as stated. and due to tha causa(s)			
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To the Hospital Within 24 hours a To the Funeral Complately filled	Σ	29b. Signatura and titla of certifiar 29c. Licansa number				29d. Data signad (Month, Day, Year)					
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40		JOGINDER F. MEHTA		SLER DRI	VE TOWSO	N, MAR	YLAND	21204			
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Regis	trar	OCT 1 2 2000	1	Anna Na							



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Helen Griser 9:30cm October 7, 2000 /Medical 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12005 Lanner Place Prince Georges [aure] If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 100 M 2□ F Yrs. 196-20-9756 83 Director February 7, PA Usuel Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD 1 Yes 2 No Prince Georges Laurel Director the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or flams 23s or 12005 Lanner Pl. 20708 USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? Unk • 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Datas: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 20 No Specify: Specify: White þ XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) flisd within Hygiene. Coltege (1-4or 5+) Elementary/Secondery (0-12) 12 3 Medica1 Nurse permit. Pages 1 and 2 should be fits.
Department of Heath and Mental Hy important: If New 27 is merked other any Injury or other to 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Edward Ross Spencer Katherine Blanche 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Betty Gooding / Daughter 12005 Lanner Pl., Laurel Maryland 20708 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State National Cem. October 12, 2000 Memphis, TN 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name end Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disaese or condition resulting in deeth) /Medical a Metastatic Pancreas Cancer 6 Months Examiner Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit death certificata be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760, Physician/Medical that initiated events reaulting in death) Last Dua to (or as a consequence of) 23h. Did tobacco use contribute to the cause of death? P.O. the Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed peed certificate has page 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 1 Residence 6 Other (Specify) 10 1 Yes 2€ No After this 27. Manner of Death 28c. tnjury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homloide to Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and manner as atated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) October 7, 2000 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz, MD 7525 Greenway Court Greenbelt MD 20770 Registrar's Signature State Registrar

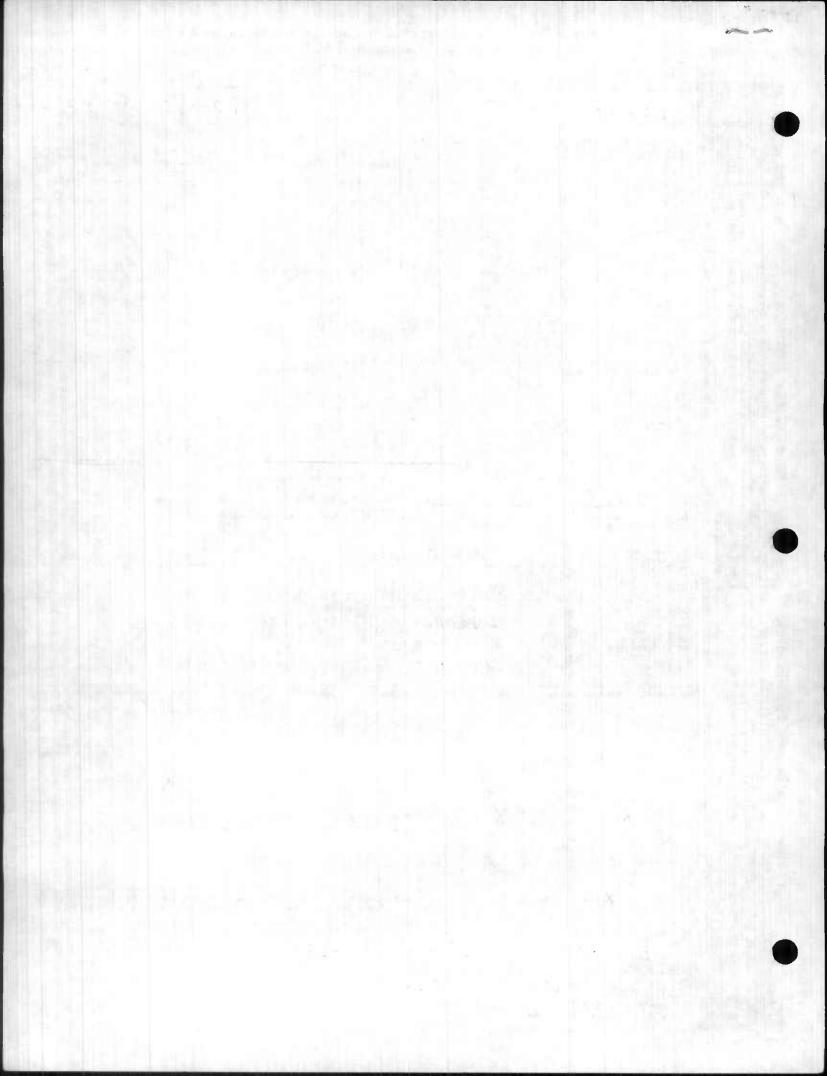


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State of Maryland / Department of Health and Mental Hygiene 0 0 3212

			Ce	ertificate o	f Death		R	eg. No.	, 0	6161			
Division	1. Decedent's Name (First, Middle,	Last)				2	Dete of Deet	h Dey	Yeer	3. Time of Death			
Physician /Medical	CHARLES GELDER 4a Facility Name (If not institution, give street and number) 4b. City, Town, or I							loth, 2		11:20 p.m			
Examiner		give street and number)			-			4c. County					
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Funeral Director	199-20-3455	. Sex 7. Age 1 1	73 Yrs.	Months Day		Min.	Date of Birth (Month, Day, Jan. 14	Year)	9. Birthple Count	ace (State or Foreign ry) MD			
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the M	10e. Street and Number		Dartimo	10f. Zip Code			1	0g. Citizen of W	What Count	nv?			
ifier death with the Mar r terms 23s or 28s-f si ninc must be notified Funeral Director	1210 Locust Ave				21227			U.S.A	١.				
d within 72 hours after death with the Maryland jiene. Jiene and The Maryland siene and the motified at the Maryland show the Maryland and the Maryland and the Maryland and Maryland and Maryland and Maryland and Maryland	11. Marital Status 1 □ Never Merried ② Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 1 Yes 2 □ No If Yes, Give Year or Dates:	1950 – 1954	. Was Decedent of If Yes, specify Co 1 ☐ Yes 2 ☐ N		gin? (Speci i, Puerto Ri	ty Yes or No- can, etc.)		e - America k, White, e Wh:				
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and 2 should be file asith and Mental Hy n 27 is marked oth her traumatic event	19a. Informant's Name/Relationship Sheila L. Gelde			altimore, MD. 21227 Date 20c. Location - City or Town, State									
Pages 1 nent of Hi int: if then iry or oth	20a. Method of Disposition **D Burial 2 Cremetion 3 4 Donation 5 Other (Spe		10- Park	Date -14-00	20c. Location - Elkrid	City or Too	wn, State						
parmit. Departin Importa any inju	21. Signature of Funeral Service Lie	Docobs.		22. Name and Add Ambrose 1 1328 Sul	Funera1	L Home			MD (21227			
	23a. Part1. Enter the disease, or co shock, or heart tailure. List or	mplications that ceused the	ne death. Do not e	nter the mode of d	ying, such as	cerdiac or	respiretory arr	est,	1	Approximate Interval Between			
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of the death ce dby the attendi	Pert II. Other significant conditions	contributing to death but	not resulting in the	underlying ceuse	given in Part I.		23b. Did to	obacco use cor	ntribute to	the cause of death			
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aw requires been 2 should				24a. Was a perfor		ave	ore autopsy findings allable prior to inpletion of cause death?						
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certificata rector, pag	25. Wes case referred to medical examiner?				26. Place	of Death	Check only or	10)					
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tal or Attending Physics after death. at Director: After this ied in by the funeral di Certification: Tc	3 Suicide 6 Could no 4 Homicide determin	28e. Place of Injury building, etc.		street, factory, office	9	28	If. Location (S City or Tow	treet and Numb n, State)	er or Rura	I Route Number,			
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within 2 To the comple	29b. Signature and title of certifier			29c. Lice	ense number		2	9d. Date signed	d (Month, i	Day, Year)			
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020	72 hours effer deeth v netural; or Hems 23- scall Examinational	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes Yes Yes, Give Year or Dates:		If Yes, spec 1 ☐ Yes 2	ify Cuban	, Mexicen, Specify:	Puerto Rio	can, etc.)		ck, White, etc.	
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State of Maryland / Department of Health and Mental Hygiene 00 32 | 29

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0	James Hoffman					Ru	th Car	rr					
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To Be Completed by Physician									101	as 2 No		daeth?]Yes 2□ No	
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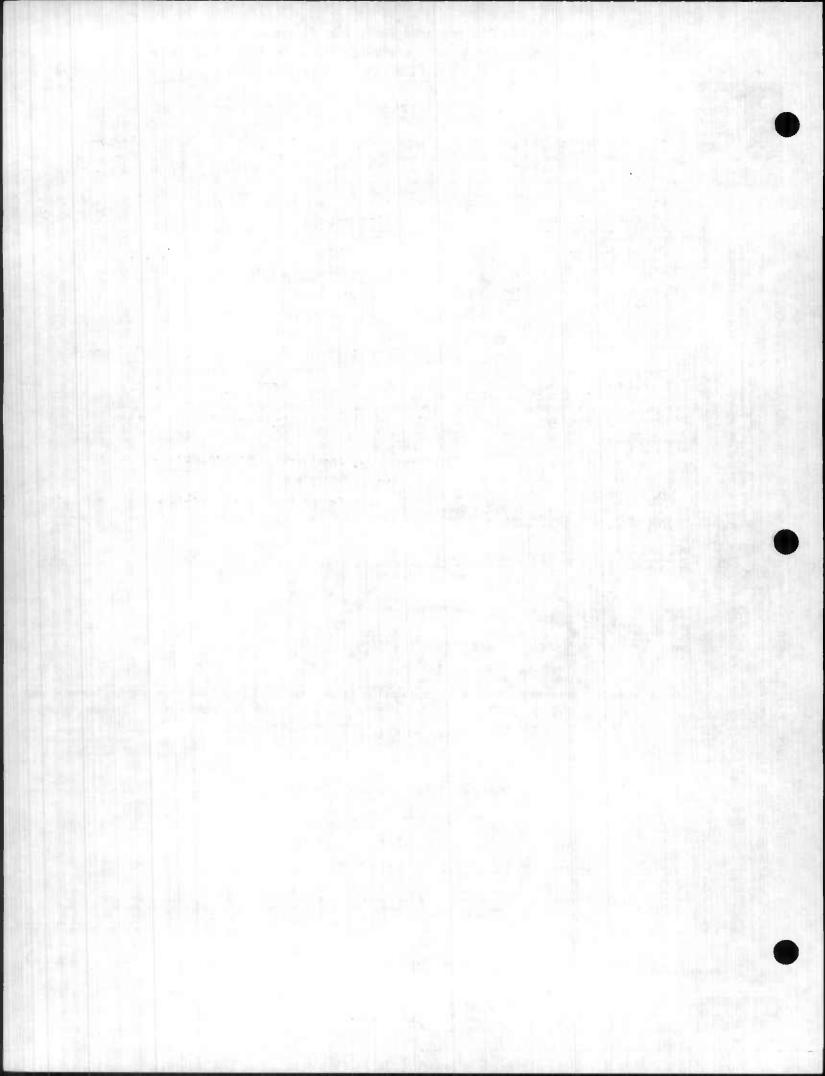
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

					erincate d	or Death		Reg. No.	• 0	4100	
	Physician /Medical	1. Decedent's Name (First, Middle, L Helen	A.	Gai	rtrell		2. Date of De Month Octob	er 10 2	Yeer 2000	3. Time of Death 9:25 am	
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	^o Funeral Director	5. Social Security Number 6.	Sex 1 □ M 2 □ F	e (In yrs. last birthda 92 Yrs	Months Da		8. Dele of Bi (Month, De Aug 6	th	9. Birthplac	ce (State or Foreign 'y) 'yland	
	yland how	10a. Stete 10b. County		10c. City, Town or	Location	100			100	d. Inside City Limits	
	ar death with the Marya florte 25s or 25s-f sho her must be notified at funeral Director	Maryland Baltin	nore		Reister					1 Yes 2 XNo	
	with the Day of 2		Road		10f. Zip Co	1136		10g. Citizen of V		y?	
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, Maryland 21215-0020	and 2 sh oath and n 27 is m ar traum	19a. Informent's Name/Relationship Richard C. Bandio		313	Ridgely	Road Lut		e, MD 2	1093	Europe.	
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Records,	The law requires that site has been signed to page 2 should be det				24a. We	s en eutopsy ormed?	avail	e eutopsy findings leble prior to pletion of cause seth?			
	The law ate has page 2						10	Yes 24 No	10	Yes 2□ No	
of Vital	ysician: The I is certificate he director, page To Be Corn	25. Wes case referred to medical examiner?	40-20			26. Plece of De			1111		
of	Physician: this certific ral director,		Hospitel: 1 Inpatie		T	how injury occur					
on	oding th. Atter fune fune	Neturel 5 Pending 2 Accident investigation	(Month, De	Injury et Work? 1 ☐ Yes 2 ☐ No							
Division	tal or Attending P is after death. al Director: After t led in by the funer Certification:	3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rura City or Town, State)									
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dimensal dim	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of end menner ste	examinetion end/or							
	within To the compl	29b. Signeture entraffic of certaffic		40	29c. Li	cense number		29d. Date signe			
		10stree				D 15504		10	10.0	6	
	6	30. Neme and eddress of person who	completed cause of d	eeth (Item 23e) (Ty	oe, Print)						
		Eddie Nakhuda,		O Dulaney	Valley	Rd Timo	nium, M	d 21093			
	State Registrar	31. Dete filed (Month, Day, Year)		er's Signeture	1 hoo	Ks					

NAME: GARTRELL, HELEN



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First Middle Last) 2. Data of Deeth 3. Tima of Death Month Day Vear October 7, 2000 Edward Lee 2 A.M. 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Pikesville Baltimore 6930 Brookmill Road If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Jan. 26, 1965 9. Birthplaca (Stata or Foraign Country) Baltimore, Md. 6. Sex 1 M 2 □ F 5. Social Security Number 7. Aga (In yrs. last birthday) Months Days Yrs 35 219-56-6915 Usuel Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location Md. 1 Yas 2 No City Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 6930 Brookmill Road USA 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 Never Married 2 Married 1 Yas 2 No If Yas, Giva Yeer or Detes: 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Maintance Man Bowling Alley 12th Grade 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Name (First, Middla, Last) Edgar L. Green Jr. Jean P. Evans 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 3560 Carrage Hill Circle Randallstown, Md. 21133 (Mother) Mrs. Jean P. Green
20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 10/9/00 Hampstead. Md. Carroll Cremation Service 21. Signature of Funeral Sarvice Licansae 22. Name and Addrass of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, Md. 21136 Em2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Daath Immediate Causa (Final disease or condition rasulting in death) VENTRICULAR FUBRILLATION

Due to (or as a consequence of): NON-15CHEMIC CAADIOMYOPATHY

Dua to (or as a consequence of): Sequentially list conditions, if any, leeding to immadiata causa. Entar Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last HYPERTENSION

Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS 24b. Were autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No 25. Was casa rafarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Assidanca 6 Othar (Specify) 1 Yas 2 No 1 | Inpatiant 2 | ER/Outpatient 3 | DOA 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Panding invastigation 1 ☐ Yes 2 ☐ No 2 Accidant 8 Could not be detarmined 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 - Homicide

Box 68760

Records, Division of Vital

altimore, Maryland 21215-0020

permit. Pages 1 and 2 should be fits Department of Health and Montal Hy Important: if them 27 is marked way injury or

Physician

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death.

To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by

Director: /

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edical Certification: To

Funeral

Director

DESAI HD 31. Data filed (Month, Day, Year) OCT 1 2 2000

29b. Signature and titla of certifier

29a. Cartifier (Check only one)

32. Registrar's Signatura

30. Nama and addrass of parson who completed cause of death (Item 23a) (Type, Print)

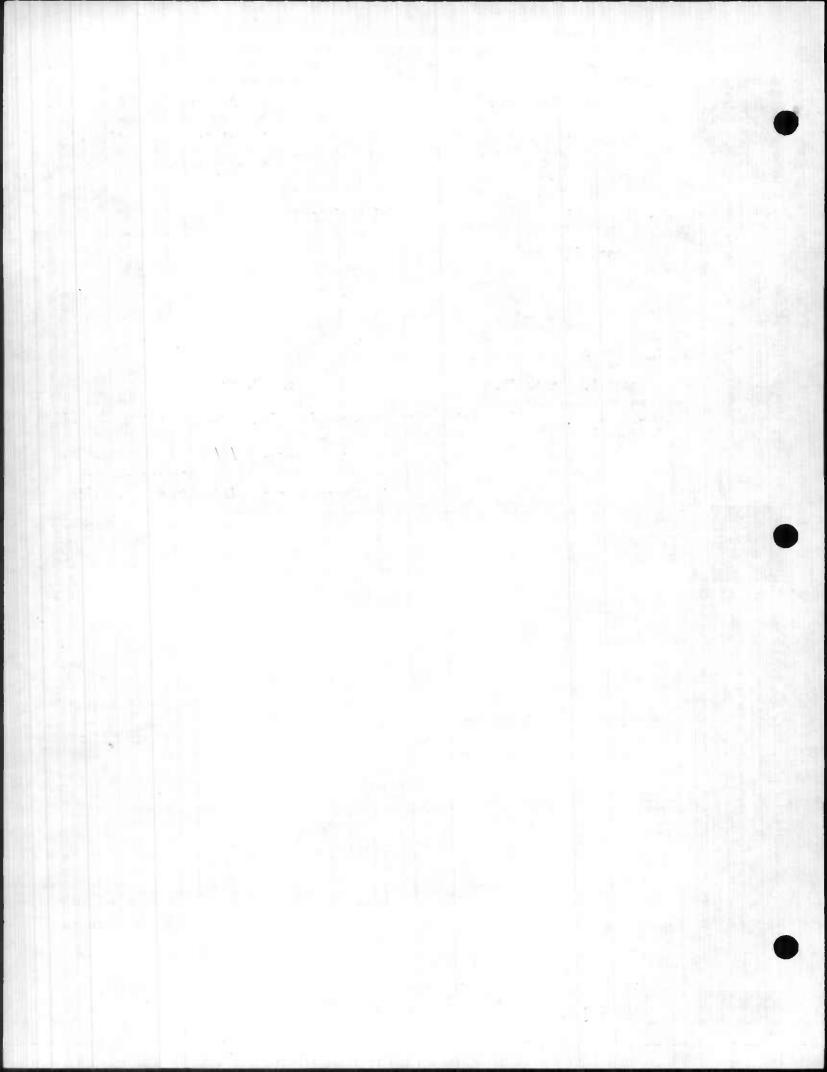
Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29d. Date signed (Month, Day, Year)

40390

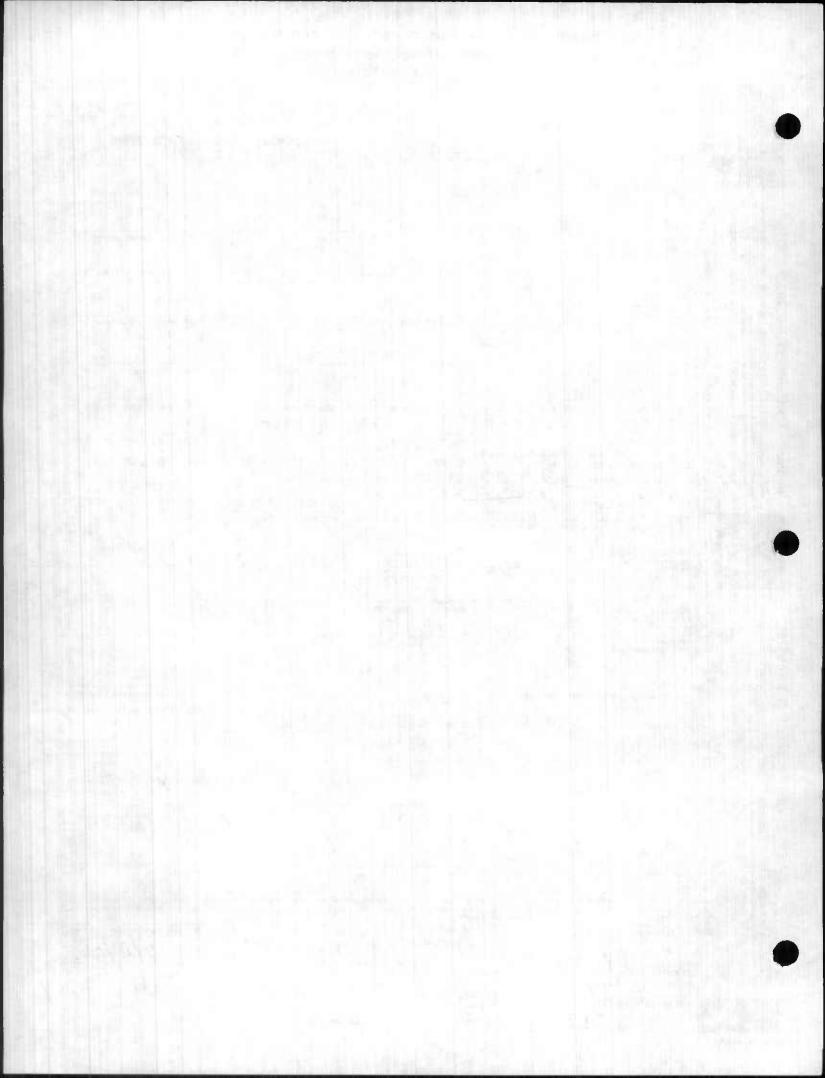
; 23 CROSS ROADS DRIVE, # 325, DWINGS HILLS, MD 2017



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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/Medical Examiner	40	Facility Neme (If not institution, gir	ve street end number)				4b. City, Town, or Lo	cation of Deeth	4c. County	of Deeth	
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other traumatic avent, tre Ma		9e. Informent's Neme/Reletionship STEPHEN M. GLUS			19b. Meiling Address 7500 SHEL		end Number or Run DD ROAD -				ode)
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ne Funeral Director: After this certificate has been signed by the attending physicia pletely filled in by the funeral director, page 2 should be detached for use as the bur edical Certification: To Be Completed by Physician/Medical	25 27 29 29	art II. Other eignificant conditions of the saminer? 1 Yes 2 No 7. Menner of Deeth 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined. 90. Certifier (Check only one)	d	Due to (or egulation of my knowle examinetion	a consequence of) a consequence	cause gh	26. Place of Deather: 4 Nursing Ho y et k? Yes 2 No	23b. Did to 1 Ye 24a. Wes e perform 1 Ye Mesidic 28d. Describe he 28f. Location (Single or Town) end due to the correct at the time, did	n eutopsymed? es 2 de lo common de lo commo	3 Probab 24b. Were evalue comp of dee 1 Year (Specify) er (Specify) er or Rurel R	autopsy findings ble prior to letion of cause ath? res 2 No No Noute Number, e ceuse(s)

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death Dev Year LETITIA GORDON 9 2:06 PM OCTOBER 2000 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Name (If not institution, give street end number) HOSPITAL CENTER BALTIMALE NORTHWEST ANDALLSTOWN If Under 1 If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) APR • 29, 1923 5. Sociel Security Number 6. Sex Birthplace (Steta or Foreign Country) 1□ M 2XF Yrs. 217-18-9174 MD Usuel Residenca of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD BALTIMORE BALTIMORE 10a. Street and Number 10f. Zip Code 10a, Citizen of What Country? 3198 OLD POST DRIVE #3 21208 U.S.A. 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-tl Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 Nevar Merried 2 Merried ☐ Yes 2 No Yes, Give 1 ☐ Yes 2 No Specify: Specify WHITE 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry SOCIAL SERVICES Elamantary/Secondery (0-12) College (1-4or 5+) INCOME MAINTENANCE SPECIALIST BALTO. CITY DEPT. OF 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) LOUIS ZUSKIN BLANCHE SAMUELS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNARD GORDON / HUSBAND 3198 OLD POST DRIVE #3 - BALTIMORE, MD 21208 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE HEBREW CEMETERY 10/11/00 REISTERSTOWN, MD 21. Signature of Funeral Servica License 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 100 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failura. List only one cause on each line. Immediete Causa (Finel diseese or condition resulting in deeth) ACUTE MYOLARPIAL INFARCTION HOUR CORONARY YEARS ARTERY DISEASE Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated avents resulting in death) Lest Dua to (or as a consequence of): Pert II. Other algorificant conditions contributing to deeth but not resulting in the undarlying causa given in Part t. 23b. Did tobacco use contribute to the cause of death? EPRESSION 1 Yss 2 No 3 Probably € Unknown 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of death? 1 Yes No 1 ☐ Yes 2 ☐ No 25. Wes case raferred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) Hospitel: 1 | Inpatient 2 | ER/Outpatient | SDOA 1 Yes 2 No 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Naturel 1 Yes 2 No 2 Accidant 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 Homicide

Examiner Box 68760. Physician/Medical signed by the a PO à Division of Vital Records. Completed certificate director, Be Certification: To

Physician

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Examiner

Director

Funeral

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Funeral

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23a or 28a-f

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21215-0020

Maryland

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Pages 1 and 2 should be

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nt of Health a

Physician

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Examiner

The law requires that the death certificate be executed the burial-tra Attending Physician: this funeral After To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

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State Registrar

edical

KOBERT 31. Dete filed (Month, Day, Year) 12 2000

MP 32. Registrar's Signature Reperent

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) 5401

OLD COURT ROAD RANDALL STOWN MD 2/13

NSCertifying Physician: To the best of my knowledge, deeth occurred et tha tima, data and plece, and due to tha cause(s) end menner as steled.

Medical Examiner: On tha basis of examinetion and/or investigation, in my opinion, deeth occurred et tha time, data end plece, end due to the cause(s) end manner stated.

29c. License number

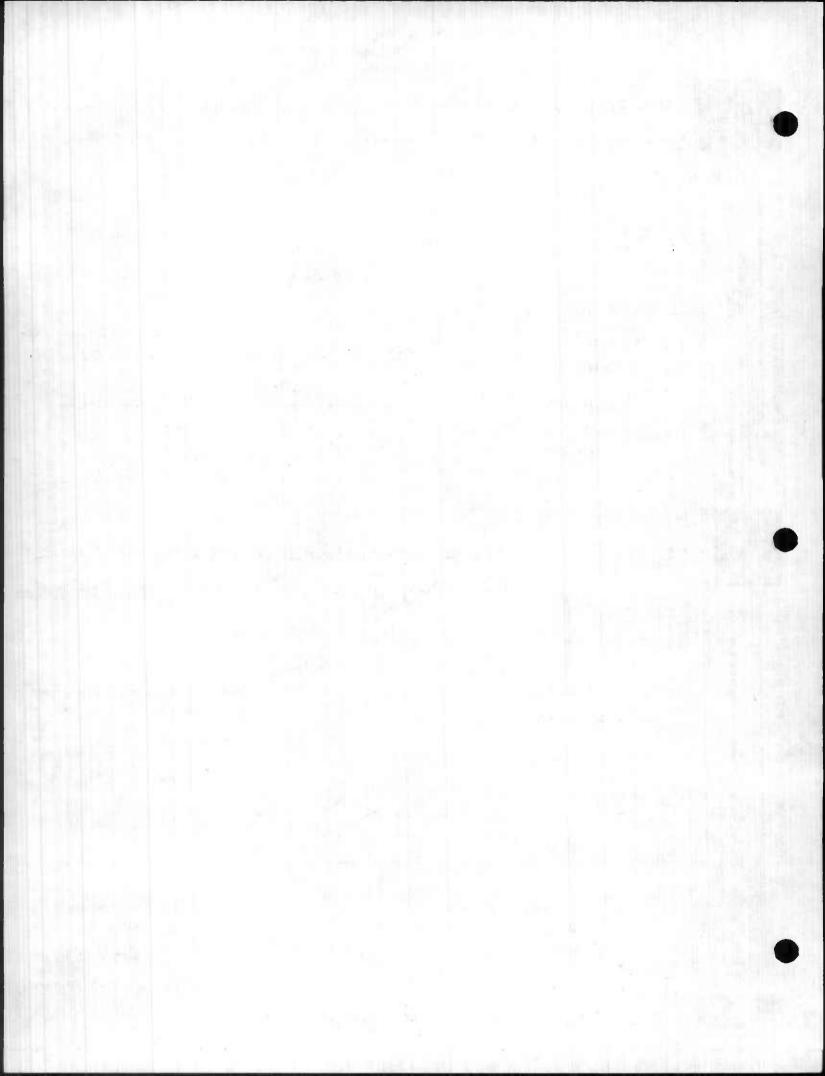
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29a. Certifian

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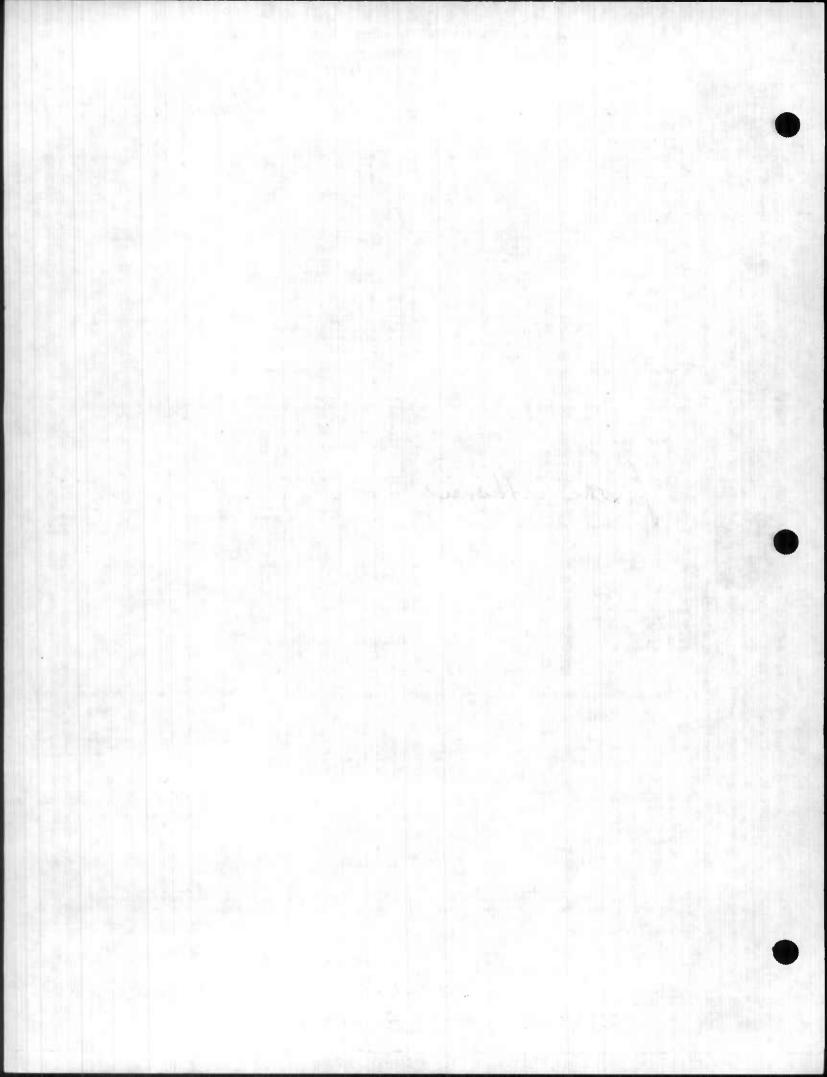
29b. Signature end title of certain



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State of Maryland / Department of Health and Mental Hygiene 00 32134

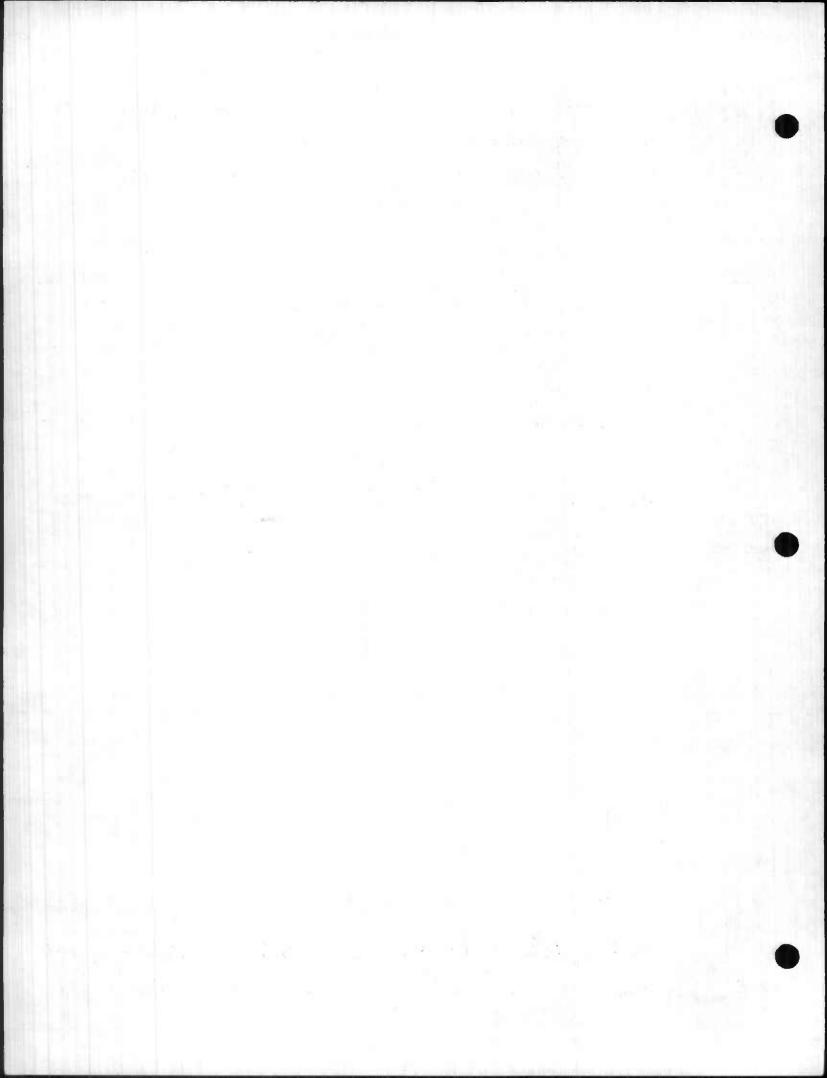
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	1. Decedent's Name (First, Middla, L	ast)					2. Data of Dea		Vala	3. Tima of Death
Physician	LISTON A. GEORG	E JR.				-	(2ctobe	P Dey	2000	435 PM
/Medical Examiner	4a Facility Nama (If not institution, gi				4b. City, T	own, or Loc	cation of Death	4c. County		
LAMITHIE	STELLA MARIS @	MERCY HOSPI	TAL		BAL	TIMOR	E	N/	A	
Funeral			(In yrs. lest birthdey	If Undar 1 Y	ear If Unde		8. Data of Birth (Month, Day			laca (Steta or Foreign try)
rector	244-90-7273	₩XM 2□ F	47 Yrs.	Months D	ays Hours	Min.	(Month, Day 1-21-1	953	Count	try)
100101	Usual Rasidence of Decedant							,,,,		
A III	10a. Stata 10b. County		10c. City, Town or L	ocation		- 1			10	Od. Insida City Limits
or flams 23s or 28s-f show infractional be notified at Funeral Director	MD. N/A		BALTIMOR	RE						1 DXYas 2 □ No
100	10e. Street and Number			10f. Zip Co	da	100 140	1	Og. Citizan of	What Count	In/2
ă		.m. 4.Dm. 0							TTIME OCCIT	.,,
in in	2120 ST. PAUL S			212				USA		
by Funeral Director	11. Meritel Status	12. Was Decedant E Armad Forcas?	var In U,S. 13.	Wes Decedent If Yes, specify	of Hispanic O Cuban, Maxica	rigin? (Spe an, Puerto f	city Yes or No- Rican, atc.)		ce - Amarica ck, White, o	
F	1 Nevar Married 2 Married	1 ☐ Yas 2∑ No If Yas, Giva		1 Yes 20	No Specify	<i>/</i> :		Specif	v:	
d L	3 Widowed 4 Divorced	Year or Detes:							BLACE	X
Completed	15. Decedent's E (Specify only highest go		16a. Dece	edant's Usual O	ccupetion	st of workin	na	16b. Kind of B	lusinass/Ind	lustry
- d	Elementery/Secondery (0-12)	Collega (1-4or 5-	lifa.	DO NOT usa n	etired)					
Ö	-12-	-2-	MA	ANAGER				RETA:	IL	
Be	17. Father's Nema (First, Middla, Las	t)			18. Moth	ner's Neme	(First, Middla,	Maidan Sumai	ma)	
To	LISTON A. GEORG	E SR.			DO	ROTHY	GIBBS			
-	19a. Informant's Name/Ralationship	(Type, Print)	19b. Mail	ing Address (Si	treet and Numi	ber or Rura	Route Numbe	r, City or Town	, Stata, Zip	Coda)
	LISTON A. GEORG	E SR(FATHER	201	SUTER I	RD. CAT	ONSVI	LLE, MA	RYLAND	21228	8
	20a. Mathod of Disposition		20b. Place of Disp	osition (Nama	of	1		20c. Location		
	1 ☐ Burial 2 ☐ Cremation 3			amatory or other		4.0	12 200	O DATE		114 Data 4 110
	4 Donation 5 Other (Space	*	METRO CH							, MARYLAND
ance.	21. Signature of Funeral Sarvice Lice	ences) of last		22. Neme and A						
8	paratha	O. TAUS	nee 17	721–27	N. MONR	OE ST	BALTI	MORE,	MARYL	AND 21217
detached for use as the burial-transit augment / Physician/Medical Examiner	Sequantielly list conditions, if any, leeding to immadiate cause. Enter Undarlying Cause (Disease or injury that inkileted avents resulting in daeth) Lest	c	Dua to (or as a conse	0						
Physician	Part II. Other significant conditions	contributing to death but	not resulting in the	undarlying caus	a given in Peri	t I.	23b. Did to	obacco usa co	ontribute to	the cause of death?
, t							101	res 2 No	3 □ Prot	bably 4 Unknown
by P										
7							24a. Wes	en eutopsy		ara autopsy findings
et							perfor	THEO! ?	CO	ellabla prior to mpletion of cause death?
Completed								4		
S							1 O Y	es 2 No	10	Yes 2 No
Be	25. Wes case raferred to medical axaminar?					ca of Death	(Chack only o	neStE//A	MAR	is At MERC
2	1 ☐ Yes 2 No	Hospital: 1 Inpatian				Nursing Hor	ma 5 🗆 Rasid	ance 6 70t	har (Specifi	HOSDICE
	27. Menner of Death	28e. Deta of Injury (Month, Day	Year) 28b. Tima Injury	of 28c.	Injury et Work?	2	28d. Describe h	ow injury occu	rred	
atio	2 Accidant Investigeti		, injury	М	1 ☐ Yes 2 ☐	□No				
Certification:	3 ☐ Suicida 6 ☐ Could not determine	Zoa. Flace of Inju	y - At homa, farm, s	traat, factory, of	ffice	2	28f. Location (S City or Tow		ber or Rura	I Route Number,
en	4 Normicida	building, etc.	(Specify)				City of Tow	n, Stele)		
edical C	(Check only 2 Medical Exa	hysician: To the best of								
	one)	end mannar stat								
Σ	29b. Signatura end titla of cartifier			29c. Li	icense number			29d. Data sign		
	m Call vole)		D	408	54	C	ctobF	Q 18	, 2000
1	30. Nema end addrass of person who	completed cause of da	ath (Item 23e) (Type	, Print)_	100.				, , ,	21202
/	Davin Dina	PERO	201 5	+ DAII	PI	F	RAH'A	ARE	Mal	2/227
04	31. Dete filed (Month, Day, Year)	32. Registra	's Signature	nau	1/	4	111111	UAL	1110	21QUZ
State		2000	a server	4 1	20 10					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician		1. Decedant's Nama (First, Middla, Las							2. Data of Da Month	Reg. No. ath Day	Year	3. Tima of Dea
/Medical	ı.	Harold	L.	Hugh	es				Oct.	9, 20	00	3:30
Examiner		4a. Facility Nama (If not institution, give 5513 Medwick						4b. City, Town, or Baltimo	ro	,	of Death	
uneral irector		213 10 0000	ax 7. □ M 2□ F	Aga (In yrs. 78	last birtho	Months	T 1 Yaar Days			h V. Year) 19 192	9. Birth Cou 2	piaca (Stata or Fo
f show		Usual Rasidance of Decedant 10a. Stata 10b. County MD				r Location LMOTE						10d. tnslda City Li 1 ŽYas 2 [
of the court of th		10e. Street and Number 5513 Medwick	Garth	South		10f. Z	p Coda	21228		10g. Citizan of V U . S	What Cou	intry?
6	2	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Deceda Armed Force X Yas 2 If Yas, Giva Yaar or Data	as? □ No		13. Was Dec If Yas, sp		Hispanic Origin? (S ban, Maxican, Puari Specify:	pecify Yas or No o Ricen, atc.)	14. Rad Blad Specify	ck, Whita,	can Indian, , atc. nite
natural, colcal Exp leted by		15. Decedant'a Ed (Specify only highast grad			16a. D	ecedent's Us	ual Occu	pation during most of wor	tkina	16b. Kind of B	usinass/Ir	ndustry
n, the Medical of the Completed		Elementary/Secondery (0-12)	Collega (1-4	or 5+)				arrier	A	U.S. P	osta	al Serv
arked other attic event	3	17. Father's Nama (First, Middla, Last) Thomas Hughes	5					18. Mothar's Nar Mak	ma (First, Middla, Del Mar	Maidan Suman tin	na)	
27 is mar r traumat	er traum	19a. Informant's Name/Relationship (7 Mary A. Hughe	Rural Routa Number, City or Town, State, Zip Code) 212 th South, Baltimore, Md.									
nt: If item ry or othe		20a. Mathod of Disposition 1 ⊠ Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Specify		20b. I	Place of Doematary,	isposition (Na crematory or hedra	ma of other ple	metery	Data 0-13-00	20c. Location - Baltimo		_
Imports any inju		21. Signature of Funaral Sarvice Licen: Handa L	Lemn	non	1470	Mitzk	o Fin	ass of Facility neral Hon ndson Ave	ne, Inc.	nsville	, Md.	. 21228
sician ledical ledical miner legister l	cian lical lner	23a. Part1. Entar tha disaasa, or complications that causad tha death. Do not antar tha mode of dying, such as cerdiac or respiratory arrast, shock, or heert tailura. List only one ceusa on aach lina. Immediata Causa (Final disaasa or condition rasulting in death) Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of):										Approximata Intarval Betwee Onsat and Deat
as the bur		Sequentially list conditions, if any, leeding to immediata cause. Entar Underlying Cause (Disaasa or Injury that Initiated evants rasulting in death) Last	c	Dua to (c	ras a cor	sequance of	:					
d for u		Part th Other classificant any distance	nt dhuting to don!	h his are are		a contact tax		to the Book t	and Dist		1	
igned by the attendir be detached for use by Physician/A		Part tt. Other significant conditions co	ntributing to deat	n but not ras	uiting in tr	a undariying	ceusa gi	Van in Part I.	1 🗆	~		to the cause of debably 4 Unk
houid beted									24e. Wes an autopsy performed?			Vare autopsy finding veileble prior to completion of ceuse death?
irrector, page 2 s									101	as No	1	□ Yas 2□ No
director,		25. Wes casa ratarred to medical axaminar?	Hospital:				01	har-	ath (Check only o			
# ·		1 Yas 250 No 27. Mannar ot Death 1 Solution 5 Pending	1 ☐ Inp.		28b. Tim Inju	a of	OA Inju	4 LI Nursing F	ing Homa 5 Aasidance 6 □Othar (Specify) 28d. Dascribe how injury occurred			fy)
To the Funeral Director: After the completely filled in by the funeral Medical Certification:		2 Accident invastigation 3 Suicide 6 Could not be datarmined	28a. Place of building,	Injury - At h atc. (Specil		, straat, facto]Yas 2□No	28f. Location (S City or Tox		ber or Rur	al Routa Number,
To the Funeral completely filled Medical C	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece (Check only one)								, and dua to the or	causa(s) and ma data and place,	annar as s	stated. to the ceuse(s)
Me Me	29b. Signatura and titla of certifiar 29c. Licensa number									29d. Data signe	d (Month,	Day, Year)
		Stylun John	lauth	W	MI)2:	3580	C	Pelole	~ 1	0,2000
2	1	30. Nama and and ess of person who co	CHOLT	ot death (Item	1 23e) (Ty	pe, Print)	VE	5.300	BALT	o. ma	2	1229
State	1	11. Data tiled (Month Day, Year)	nn 32. Regi	strar's Signa	jura		1			" " /	, ,	- •



23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en autopsy performed?

24b. Were eutopsy findings available prior to completion of cause of deeth?

21286

Approximete Interval Between Onset end Death

1235 PM

Birthplaca (Stete or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

2004

white

1 Yes 2 2 No 1 Yes 20 No

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Sesidence 6 □Other (Specify)

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28d. Describe how injury occurred 28h Time of 28c. Injury et Work? 1 Yes 2 No

28a. Dete of Injury (Month, Dey Year) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

50087

29d. Date signed (Month, Day, Year) October 11, 2000

30. Neme and eddress of person who comple (cause of deeth (Item 23a) (Type, Print)

10 N. Greene Street Paltimie, MD Parafiel Bultmire VAMC MI

31. Dete filed (Month, Dey, Year) 32 Registrar's Signatura 2 2000

State Registrar

Be Completed by

Certification: To

Medical completely

25. Wes case referred to medical examiner?

29b. Signeture end title of certifier

5 Pending Investigation

6 Could not be determined

Yes 2 No

27. Menner of Deeth

Neturel

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

funeral director,

filled in by

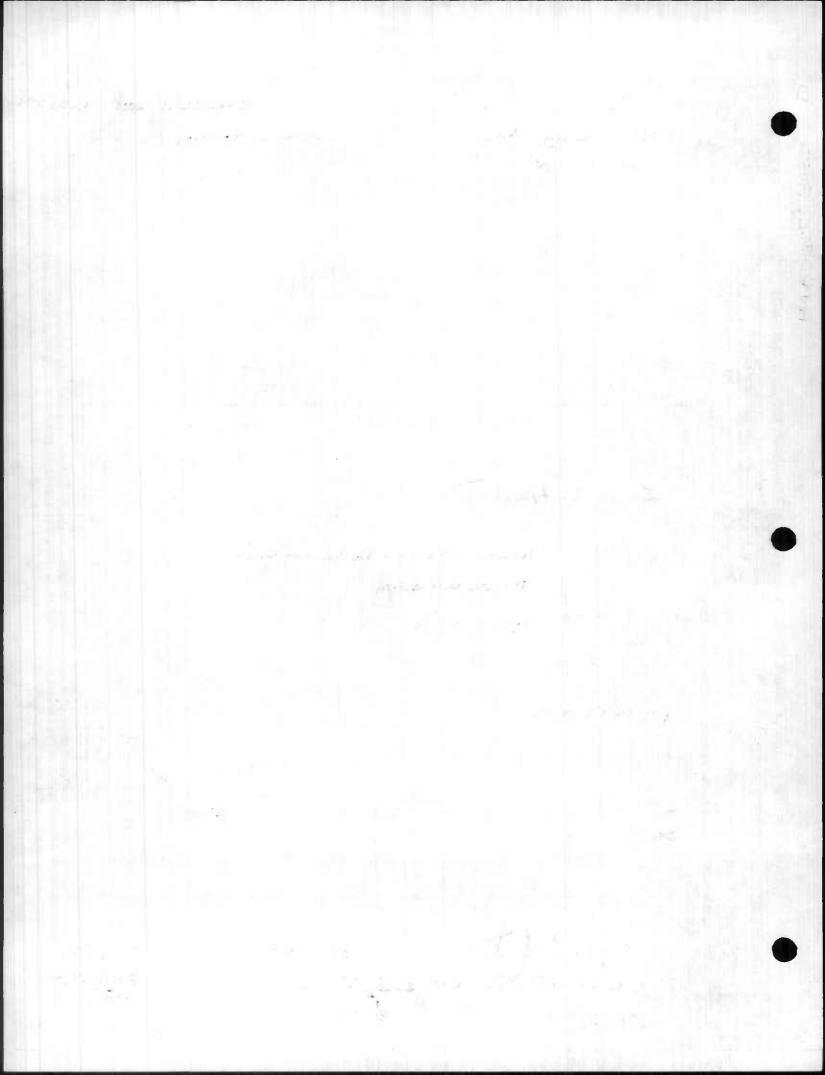
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death.

To the Hospital or Attendential within 24 hours after deat To the Funeral Director:

DHMH 16 Rev 6/95

Division of Vital or Attending Physician:



		1. Decedent's Neme (First, Middle,	Last)		Cer	tificate of	Death	2. Dete of De	Reg. No.		3. Time of Death								
Physicia	n	Marie B. Hyatt						Month	Dey	Year 000	9:20 PM								
/Medica Examine		te Fecility Neme (If not institution,	give street and number	7)			4b. City, Town, or L	Octobe ocation of Deat			9.20 111								
Funeral		Mariner Health 5. Social Security Number 6	Care S. Sex 7. A	ge (in yrs. las		If Under 1 Year		nie 8. Date of Bir (Month, De	rth sy, Year)	9. Birthp	lace (State or Foreign								
Director		220-05-2104 Usuel Residence of Decedent	1 W 243 F	80	Yrs.			July 9	, 1920	Mary	land								
ž 11	-	10a. Stete 10b. County		10c. City, 7	Town or Lo	cation		10.77		1	Od. Inside City Limits								
or Herrs 23a or 28a-f show kniner must be notified at	Director	Maryland Baltin	nore	Lan	sdown	10f. Zip Code			10g. Citizen of	What Cour	1 ☐ Yes 2X No								
100		204 4th Avenue				21227				5.A.	,								
Nems 22 Dec.mus	Funera	11. Meritel Status	12. Wes Deceden Armed Forces	?	13. V	Vas Decedent of	Hispenic Origin? (Sp ben, Mexicen, Puerto	pecify Yes or No Picen, etc.)	o- 14. Ra	ca - Americ ck, White,									
42	by	1 ☐ Never Merried 2 ☐ Merried 3 ☑ Widowed 4 ☐ Divorced	d 1 Tes 2 S If Yes, Give Yeer or Detes		1	I□Yes 2⊠No	Specify:		Specif	y: Whit	:e								
"natur adicai	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	lent's Usuel Occu kind of work done OO NOT use retin	during most of wor	king	16b. Kind of 8	usiness/Inc	dustry								
Than Its	omb	Elementery/Secondery (0-12)	College (1-4or	5+)		emaker			Own H	lome									
	Be C	17. Father's Neme (First, Middle, La	ast)				18. Mother's Nem	ne (First, Middle	, Maiden Sumai	me)									
arkad atic e	10	Warren H. Holt				100	Myrt	le A. K	eppler										
1 1		19e. Informent's Name/Reletionship		11/9 1			et and Number or Ru												
127		William W. Hyatt	t, Jr. / so			Glen Al	den Drive												
int: If he inty or of		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spe		cem	etery, crem	netary or other plant Ceme		0/14/00	Baltim		Maryland								
Departi Importa any inji		21. Signature of Funeral Service Lic	censee	1,	22			Home, I	nc.										
23.00	1	unn	1. sun	K)			21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Hubbard Funeral Home, Inc.												
						4107 Wi	lkens Ave	nue. Bai	ltimore,	Mary									
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or hear failure. List only due caused on each line.																		
			1		,	er the mode of dy	ring, such es cerdiec	nue, Ba	ltimore,	, Mary	Approximete Intervel Between Onset end Death								
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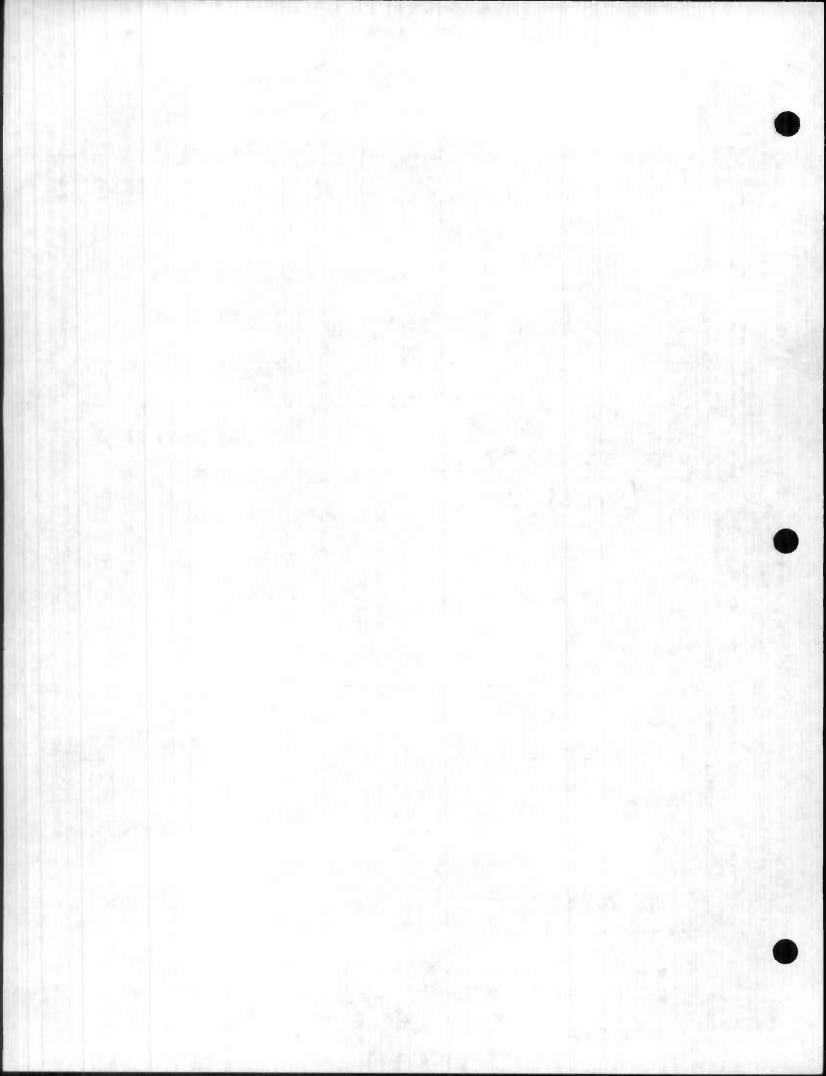
State Registrar

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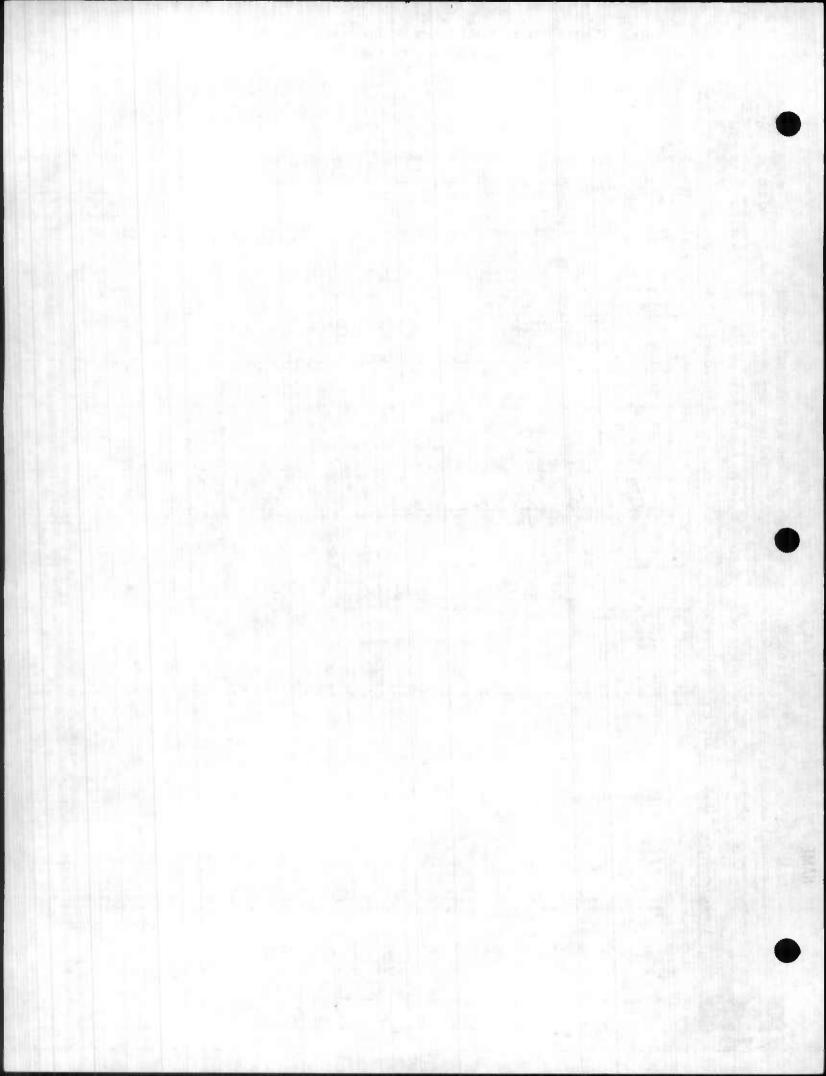
32. Registrer's Signeture

ORIGINAL



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					Cen	ificate of	Death		Reg. No.		2100				
		Decedent's Name (First, M.)	fiddle, Last)					2. Dete of Dee	Dey	Year	3. Time of Death				
	Physiciar /Medica	LUIELLA IIIII	n					OCTOBER	08 6	2000	0212				
	Examine	A. Franklin blanca de calacida	ution, give street end nun	n <i>ber)</i>			4b. City, Town, or L		4c. County	of Death					
			Huspita 1				RALTIN	10RE		n/a					
	*Funeral	5. Social Security Number		7. Age (In yrs. In	ast birthday)	If Under 1 Year	If Under 24 Hrs.		h	9. Birthpl	lace (State or Foreign				
	Director	294-18-6745	1□M 20%F	83	Yrs.	Months Days	Hours Min.	OCTO BCA	11 1916	New	York				
STORE OF	71	Usuet Residence of Deceden													
	A ST	10a. Stete 10b. Co.	unty	10c. City	, Town or Loc	ation				10	0d. tnside City Limits				
	Maryla of sho	Maryland Bal	timore	C	atonsv	i11e					1 ☐ Yes 2 No				
	vith the Ma	10e. Street and Number	CIMOTE		a cono (10f. Zip Code			10g. Citizen of V	Vhat Coun	try?				
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	her death viber rough	508 Lafayette		edent Ever in U.S	S. 13. W			pecify Yes or No-	United	a - America					
	or Herne	1 Never Married 2	Armed Fo	rces?	if	Yes, specify Cut	Hispanic Origin? (Sp pan, Mexican, Puerto	o Rican, etc.)	Biac	k, White, e					
20	ors at		If Yes Giv	e **	1	☐ Yes 2M No	Specify:		Specify	: Wh	ite				
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Maryland 21215-0020	te and	19a. Informant's Name/Relat	ionship (Type, Print)				t and Number or Ru								
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ore ore	T the Day	20e. Method of Disposition	ion 3 Removel from :	00	aca of Dispos metery, crem	ition (Name of atory or other pla	aca)	Date	20c. Location -	City or To	wn, State				
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Baltimore,	a report	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc.													
m	24 4 8	22. Name and Address of Paciniy Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229													
	//MPT	23a. Pert1. Enter the disease	e, or complications that c	aused the death	. Do not ente	the mode of dy	ing, such as cerdiac	or respiratory er	rest,	id Z	Approximete				
	Physician	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heert feilure. List only one cuse on each line. Approximate Intervet Between Onset end Deeth													
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3 9	nbe.							24a. was perfo	en autopsy med?	ava	aitable prior to				
100	as by 2 at									of	mpletion of ceuse death?				
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+11 ToN Vital Records,	ysician: The law is certificate has director, page 2	25. Was case referred to me	dical		-		26. Place of Dea	ath (Check only o	ne)						
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NAME	or A after Dire	4 ☐ Homicide	termined 286. Place building	ng, etc. (Specify)	et, factory, office		City or Tov	vn, Stete)						
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	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Madizel Certification:	one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)													
	F ¥ F 8	200.0.9		Deche	217	0	11/1///	15							
		MEDICAL RESIDENT / 1440 OCTOBER 8 2000													
	10	30. Name and address of per	son who completed caus	e of death (Item	23a) (Type, F	rint)		- 11001							
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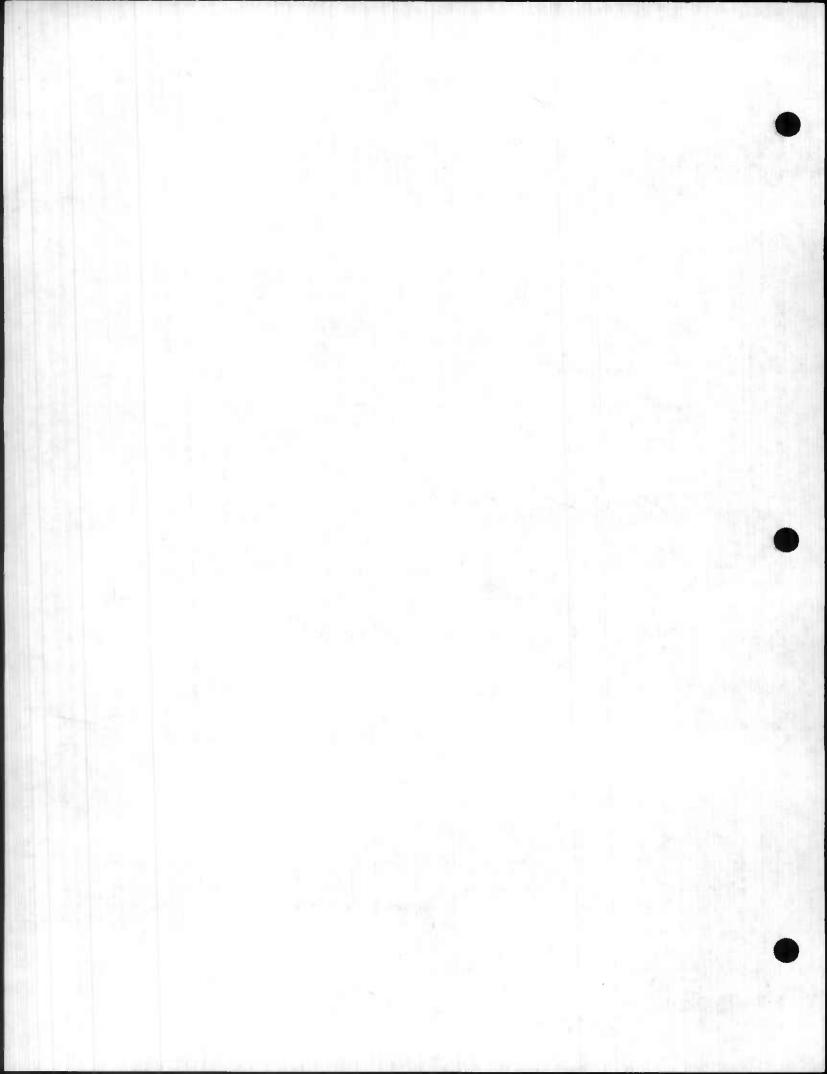
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State of Maryland / Dep

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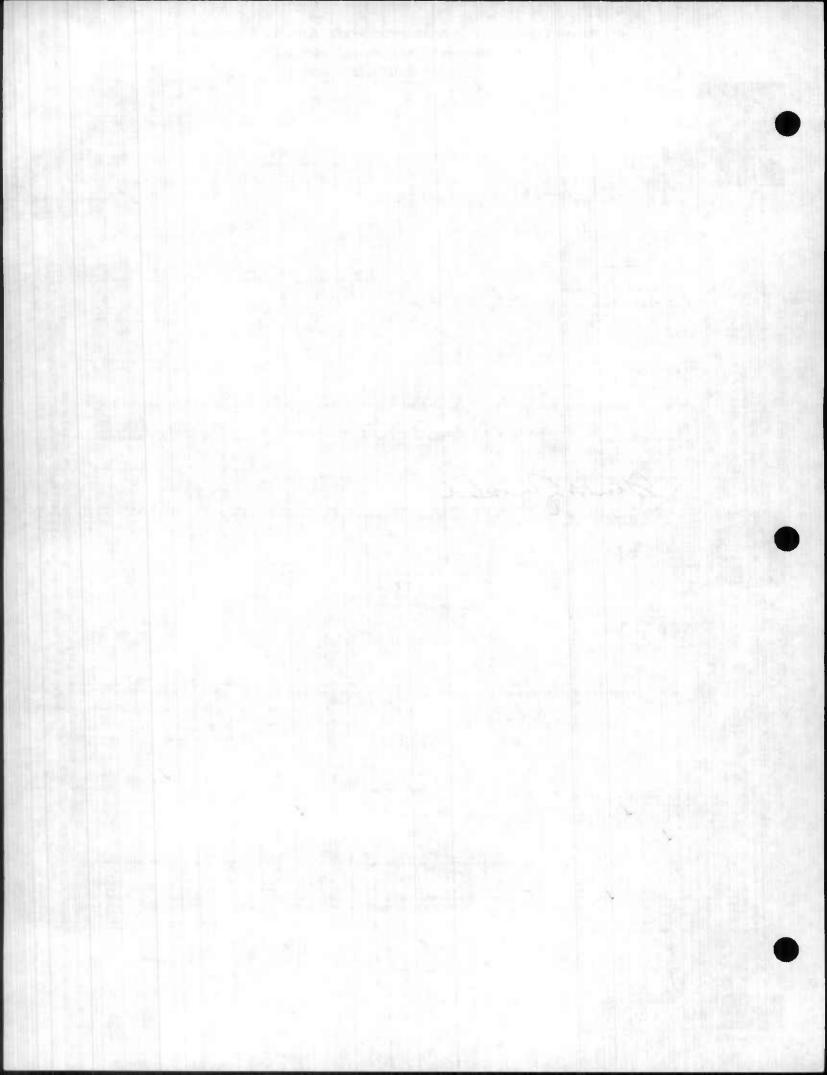
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/Medical Examiner	ALTERNATION OF THE PERSON NAMED IN	(If not institution, git ast Fort		m <i>ber</i>)			1			cation of Deat		y of Deeth		
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ms 23a or 28a-f show rmust be notified at neral Director	10a. State	10b. County	'a		ity, Town or Lo							1		e City Limit: res 2 □ No
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tem 27 is marked other other traumatic event, To Be C	Melvin	Hennes	sy					Audi	rey	Wagner				
E 5	19e. Informant's N	Name/Relationship	(Type, Print)		19b. Meili	ng Address (Street		_		er, City or Town	, State, Zip	Code)	
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5 70	27. Menner of Deeth 28e. Date of Injury 28b. Time of 28c. Injury Wo									me 5 Res 28d. Describe	how injury occu	her <i>(Specil</i> rred	^{yy} at	scen
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State of Maryland / Department of Health and Mental Hygiene 0 32 140

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ľ	Funeral Director		5. Social Security Number 220-46-9499	6. Sex 1 □ M 2 □ XF	-	e (In yrs. last bir			r 1 Year Days			8. Dete of Bir (Month, Da JUN 28		,	9. Birthp		e o <i>r Foreig</i> n
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-		-	Edward A. 23a. Part 1. Enter the disease, or	Gregor		k I the death Do	3() I F	red	eric	K RC	had Ca	ton	svi	lle,	MD	21228
	Di		shock, or heart failure. List	only one cause on	each li	10.	iot orito		so or cyn	19, 50011 45	our dia o	or respiratory a				Approxim Interval E Onset ar	Setween d Death
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B.	the attar		Part It. Other significant condition	ns contributing to	death b	ut not resulting in	the un	derlying	cause div	en in Part I	1.	23b. Dld	tobacc	o uae co	ntribute to	the caus	e of death?
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Records,	v requires been sign should be	Completed		Par	kir	of C	~~	_				24a. Was	en automed?	opsy	av	ere autop: ailable pri mpletion o death?	
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Division	or Attendant dans Director:	Certification:	3 Suicide 6 Could r 4 Homicide determ	not be 28e. Plac	e of Inj	ury - At home, fa c. (Specify)	rm, stre	et, factor	y, office			28f. Location (City or To			oer or Rura	al Route N	um <i>ber</i> ,
F		edical		g Physician: To th Examiner: On the and ma	besis of	examinetion en											e(s)
	vithin o th	Z	20h Sinnature and title of certifier										29d. D	ate signe	d (Month,	Day, Year)
	3		* Blue	Luo,	TT	my/			D 3	694	+2	Note	0c	tobe	er 1	0, 2	000
	ally		30. Name and address of person of the state	who completed car	ise of d	eath (Item 23a)	FType, F	gint)	K	Ra. (Ceto	~ystl	le,	My	21	228	,
	State	2	31. Date filed (Month, Day, Year)	Sen 32.	Registr	orle Signeture	2000	11									



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Yeer Vernon J. Horn October 10, 2000 position of Deeth 4c. County of Deeth 3:31AM 4e Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 2725 Mayberry Road Taneytown Carroll Birthplece (State or Foreign Country) 5. Sociel Security Number 218-36-9938 If Under 1 Yee 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Hours Months X□ M 2□ F 59 Aug. 28, 1941 Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Carroll Taneytown 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 2725 Mayberry Road 21787 USA 12. Wes Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 XYes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 Yes 2 XNo Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) United States Post Off Postmaster 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Jessie Wheeler Byron L. Horn 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2725 Mayberry Rd., Taneytown, MD Barbara O. Horn 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Dulaney Valley Mem. Gard. 10/13/00 Timonium, MD 21. Signature of Fulleral Service Licensee 22. Neme end Address of Fecility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 plications that caused the deeth. Do not enter the mode of dying, such as cardiac or respirelory errest, one cause on each line. Metastatic Cancer Immediate Ceus Luna 6 months disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or es a consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy parformed? 1 ☐ Yes 2 ☐ No 1 Yes 2 Ho 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4□ Nursing Home 5 Residence 6 □ Other (Specify) 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 PNatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Physiclan/Medical Examiner physician and s the burial-trensit or Attending Physicien: The lew requires that the death certificate be executed Box 68760 P.O. signed b Division of Vitai Records. After this To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun

þ

Completed

Be

Medical Certification: To

4 Homicide

29b. Signeture end title of certifier

29a, Certifier (Check only one)

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Funeral

Director

r then "natural", or flems 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after inent of Heelth and Mentel Hygiene. Int: If Item 27 is marked other then "natural", or Ite

permit. Page Department of important: If any injury or once.

Physician

/Medical

Examiner

altimore, Maryland 21215-0020

deeth with the Maryland

DHMH 16 Rev 6/95

State Registrar

INTERNIST, MD

29c. License number 1 52035

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

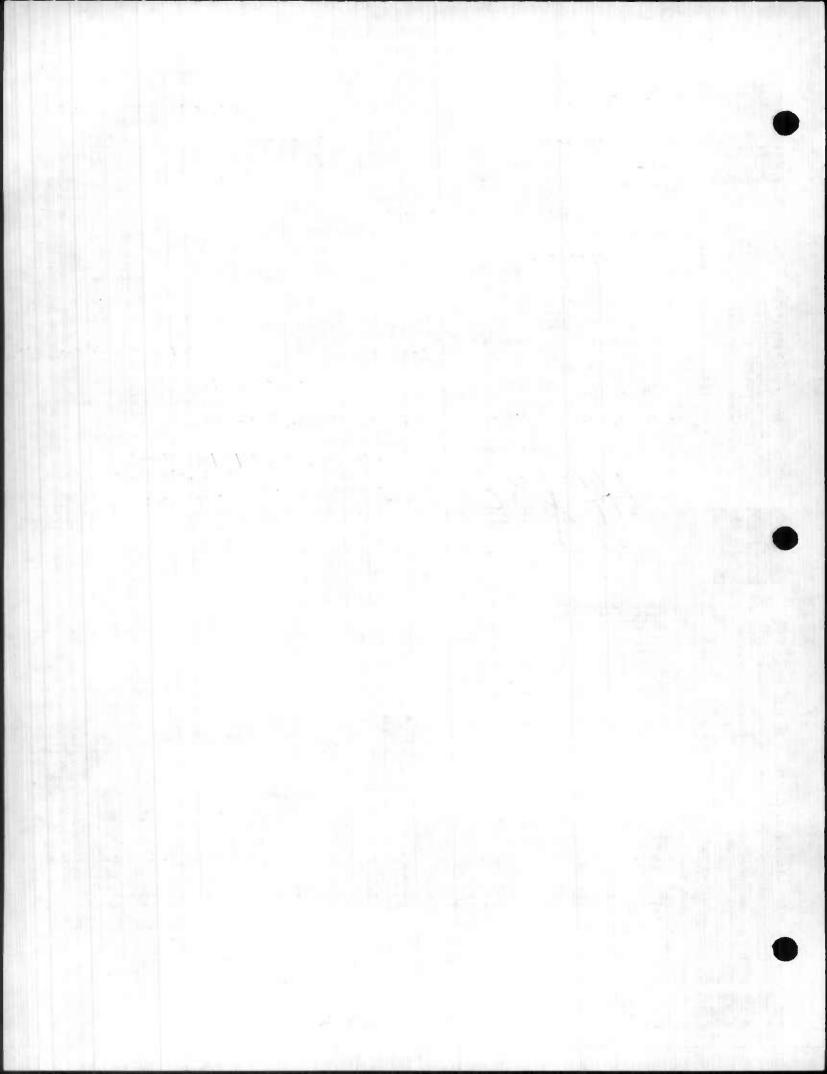
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Dey, Year) October 10, 2000

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) BINU CHACKO

291 Stoner Avenue

Westminister ND 21157

31. Dete filed (Month, Dey, Year) OCT 1 2 2000 32. Registrer's Signeture



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene REPLACEMENT Certificate of Death Reg. No. OC 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death Dey **Physician** 26 September 00 4:15 PM Samuel Jagers /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Mariner Health of Silver Spring Silver Spring M If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth Morths Deys | Hours | Min. | (Month, Dey, Year) Montgomery 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 100 M 2□ F Months Deys Hours Yrs. 79 10/16/1920 Liberty, Ms. Director 428-14-2138 Usuat Residence of Decedent with the Meryland 10e, Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f ahow TXXYas 2 No Director DC Washington the Medical Exeminer must be notified 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? items 23s or 1401 Hemlock Street, N.W. S. A. 20012 Funeral filed within 72 hours after deeth 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 12. Wes Decedenf Ever In U,S. Armed Forcas? th⊟Yes 2 No If Yes, Give Yeer or Detes: 1/20/45 1 Never Merried 2 Merried 5 Black Maryland 21215-0020 1 ☐ Yas 2 No Specify: þ 3 ☐ Widowad 4 ☐ Divorced "natural". Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use rating) Professional Officer 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) I Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) U.S. Army 5+ yrs other 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Nema (First, Middle, Last) Pages 1 and 2 should be nent of Health end Mental ant: If Item 27 is marked o Lena Caston Aaron Jagers 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Carole Jagers / wife 1401 Hemlock Street, N.W. Washington, DC Baltimore, 20b. Ptece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Department of important: If It any injury or o XXBuriel 2 Cremation 3 Remove from State 10/5/00 Arlington National Cem. Arlington, Va. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Latney's Funeral Home Inc. CC0348 3831 Georgia Avenue, N.W. Wash., DC 20011 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician 6 Locers Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Lest use as the burial-trer Box 68760, Due to (or es a consequence of) P.O. I 23h. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings eveilable prior to completion of causa of death? 24a. Wes en eutopsy performed? Be Completed certificate hes 1 Yes XX No 1 ☐ Yes 2 ☐ No lai or Attending Physician: The standard and an area desired. Solution of the standard and a standard and an area of the standard and an area of the standard and an area of the standard and area 25. Was case referred to medicel 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 45 Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours To the Funeral To the Hospital **XCertifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signatura and title of certifiar 29c. License number 29d. Dete signed (Month, Dey, Year)

State Registrar

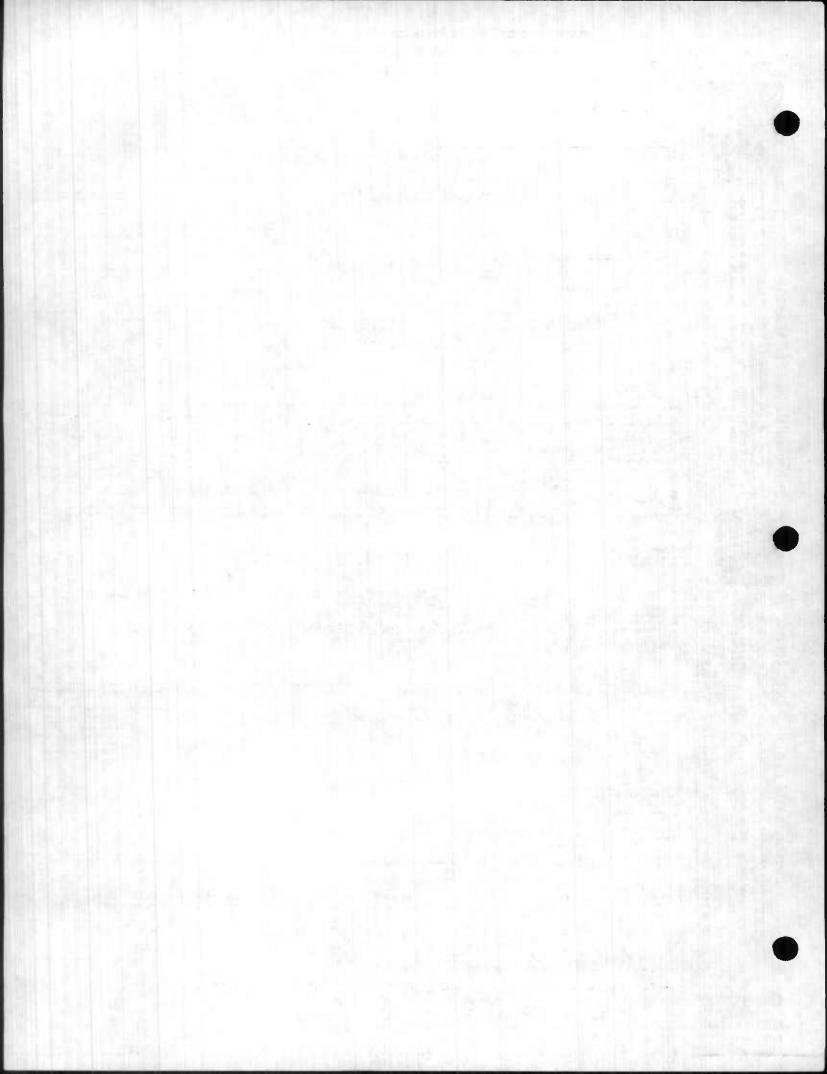
Barry N. Rosenbaum 3720 Farragut Avenue, 31. Dete filed (Month, Dey, Year) 32. Registrants Signeture DCT _ 8 2000

30. Name end address of person who completed ceuse of deeth (Item 23a) (Type, Print)

D09834

Kensington, Maryland 20895

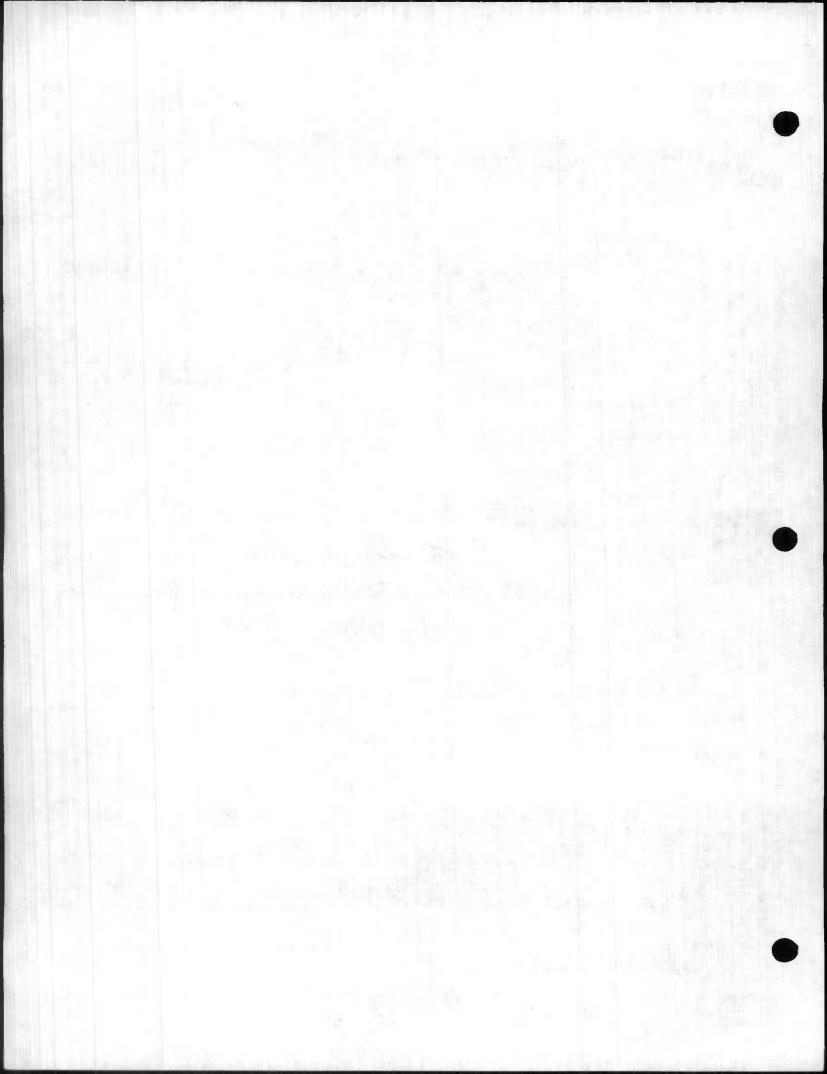
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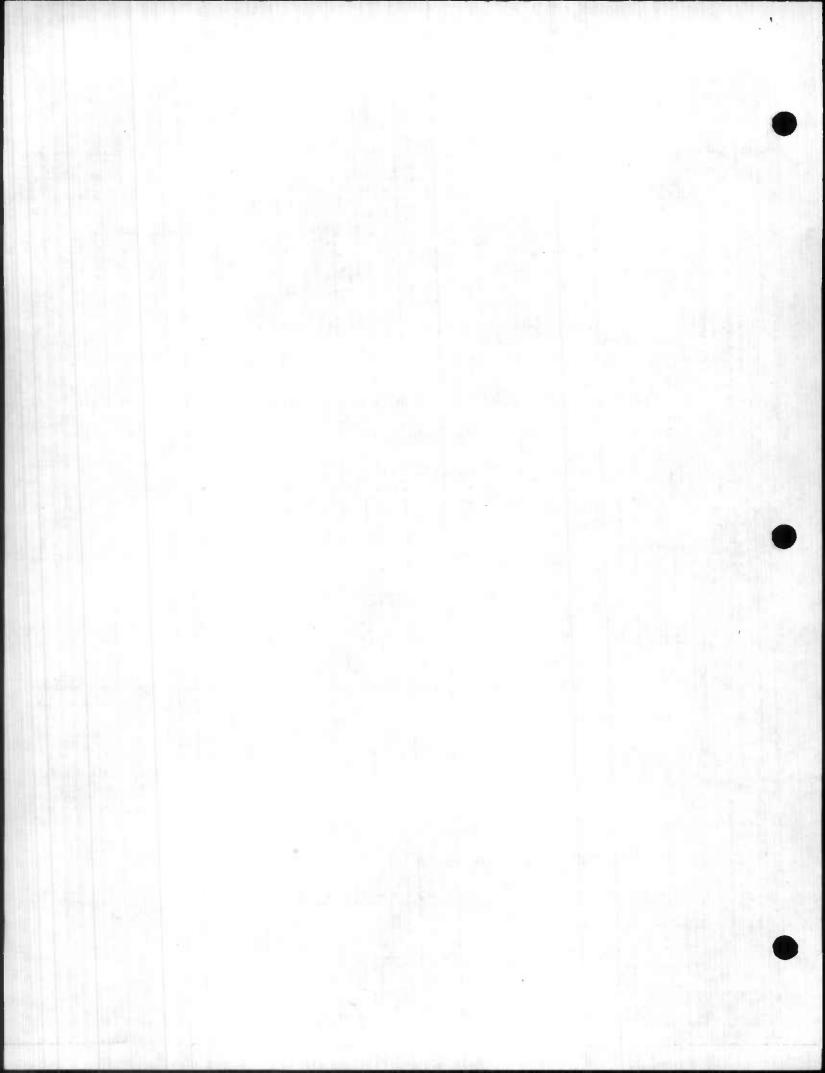
State of Maryland / Department of Health and Mental Hygiene 0 0 32143

				Certifica	ate of	Death		Re	g. No.	, 0	C 1 '1	0	
Decedent's Name (First, Middle, Last)								2. Date of Death Month Day Year 3. Time of Death					
John J	John Joseph Kessler							Oct. 8,	2000		9:10	AM	
4a Facility Name (If no	not institution, give	street and number)				4b. City, To	wn, or Loc	cation of Death	4c. County	of Death			
	onial Dr.							m Heigh					
5. Social Security Num	Monti	der 1 Year hs Deys	If Under Hours	24 Hrs. Min.									
212-34-6641 X M 20 P 64 Yrs.								May 29, 1936 MD					
	Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Lim										v Limits		
											1 🗆 Yes		
MD 10e. Street and Numb		lore	LIIICII.			-		10	g. Citizen of V	Affact County		Λ	
										VIII COUNT	у:		
	8 Colonial Dr.				ver in U,S. 13. Was Decedent of Hispanic Origin				U.S.A.	Raca - American Indian,			
11. Marital Status 1 Never Married	d dCVMarried	Armed Forces? If Yes, specify 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			pecify Cub	ecify Cuben, Mexicen, Puerto Rican, etc.)			Black, White, etc.				
3 ☐ Widowed 4 [Yes 2 No Specify:				Specify: White				
100	5. Decedent's Edu				adent's Heuri Occupation			1	6b. Kind of B	Business/Industry			
(Specify	only highest grad			(Give kind of work done life. DO NOT use retin			e during most of working red)						
Eiementary/Second	dary (0-12)		Warehouse					Cour	Courior				
17. Father's Name (Fit	irst, Middle, Last)	1 44.6				er's Name	(First, Middle, N						
Christi	ian G. Ke	essler, Sr				He:	len A	en A. Slater					
Christi 19a. Informant's Nam-	ne/Relationship (T	vpe. Print)	19b.	Mailing Addr	ess (Street	and Numbe	er or Rura	l Route Number.	City or Town.	State, Zip (Code)		
									hber, City or Town, State, Zip Code) Heights, MD. 21090				
20a. Method of Dispos			20b. Plece of	Disposition (Name of				0c. Location -				
1 🗆 Burial 2 🗖	Cremation 3 □F	Removal from State		Crematory		ce)	10	-12-00	Cator	nsvill	Le, MD		
	Other (Specify)		Heero			on of English	1	12 00	ou co.		, 115		
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc.													
	appears for 1328 Sulphur Spring Rd. Arbutus, MD. 21227												
23a. Part1. Enter the shock, or heart f	disease, or compl failure. List only o	lications that caused ne cause on each lir	the deeth. Do n	ot enter the n	node of dyli	ng, such as	cardiac o	r respiratory arre	st,		Approximate Interval Bety	ween	
		6) ,	-			0		Unset and Death			7	
Immediate Cause (Fir disease or condition resulting in death)	inal	a. <i>E</i>	expu	elny	17	ail	len	re			1056	2	
			Due 16 (or as a c	onsequerica	of):				0	1			
Sequentially list condi		b. //	lelas	lal	e (a	rce	nomo	15one		14		
Sequentially list conditions, if any, leading to immediate								7			/ 1		
Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Cause. Enter Underlying Cause (Disease or injury Cause (Disease or injury Cause) Company (Final disease or injury Cause) Due to (or as a consequence of): Company (Final disease or injury Cause) Due to (or as a consequence of): Due to (or as a consequence of):													
Cause (Disease or Injury that initiated events resulting In death) Last Cause (Disease or Injury that initiated events resulting In death) Last Due to (or es e consequence of):													
		d											
Part II. Other eignifica	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death?					
						1 🗆 Ye	1 Yes 2 No 3 Probably 4 Unknow						
									24a. Was an autopsy 24b. Were autopsy findings				
						248				Was an autopsy performed? 24b. Were autopsy findings available prior to completion of ceuse			
									of death?				
								1 □ Ye	s 202 No	10	Yes 2	No	
25. Was case referred examiner?		Maashali			100		e of Death	(Check only one	в)			_	
1 □ Yes ØX No	0	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ D				4 LI NI	ursing Hor)		
27. Manner of Death Natural		28a. Date of Injur (Month, Da)	Year) 28b. T	jury	28c. Inju			28d. Describe ho	8d. Describe how injury occurred				
27. Manner of Death Shatural 2 Accident 3 Suicide 4 Homicide	2 Accident Investigation M 1 Yes 2 No						No						
3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)						1	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only 2		sician: To the best of iner: On the basis of										i)	
one) and mannay stated.													
29b. Signature and titl	29b. Signature and title of certifier 29c. License number							25	d. Date signe	Date signed (Month, Day, Year)			
4"					125044				15/15/00				
30. Name and address	s of person who co	ompleted cause of de	eath (Item 23a) (Type, Print)		-112							
/	M-KEE	+mAn/	MD		2717	Hammo	onds	Ferry Ro	l. Lans	downe	, MD.	2122	
29b. Signature and titl	itle of certifier as of person who co	and manner sta	ited.		29c. Licens	Se number	14	25	9d. Date :	signe	signed (Month, C		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 32 | 14 |

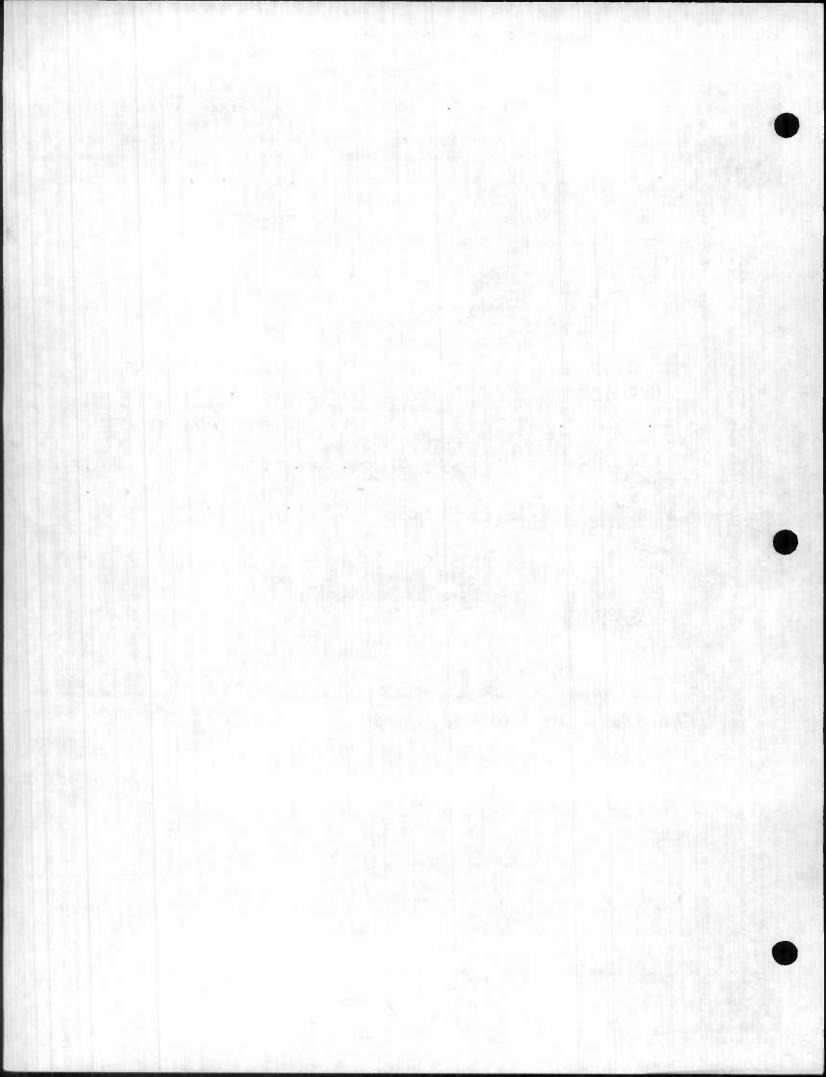
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Phys /Me	sician edical	Henrietta	Month										
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	_1	Northwest Hosp.	Hal Center	-				Lee Us to				nore	
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15-0020 72 hours after deeth with the Meryland "natural", or tems 23s or 28s-1 show alca Examinar must be notified at		Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Lie										Od. Inside City Limits	
	ō	MD Baltimore										1X Yes 2 No	
	9	10e. Street and Number	1	Of. Zip Code	13.16		10g. Citizen of Whet Country?						
	0	6811 Campfield			2120	7							
	y Funera	11. Meritel Status 1 Navar Married 2 Merried	12. Was Decedent Eve Armed Forces? 1 Yas 2 No If Yes, Give	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto f				ecify Yes or No- Rican, etc.) 14. Race - A Bteck, W Specify:			American Indian, Vhite, etc. White		
	2	3 ₩idowed 4 Divorced	Year or Datas:		On Considerate Manual Constraints				10h Vind of I			h. nêma	
15- n 72	Completed	15. Decedent's E (Specify only highest gra		6a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)				16b. Kind of Business/Industry					
within within than	d L	Elementery/Secondary (0-12)	College (1-4or 5+)					medical					
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	To Be	Henry Debelius				ildred 1	red Hall						
	-	19a. Informent's Neme/Retetionship (19b. Mailing Address (Street and Number or Run 1719 Fleetwood Drive							ate, Zip Code)	
		Donna Connelly/ni						ve Bela	air,	MD 21015			
of He		20e. Mathod of Disposition 1 Buriet 2 Cremetion 3 4 Donetlon 5 Other (Special	Removat from Steta		of Disposition (Name of tery, crematory or other place) Dete 20c. Local						ocation - City or Town, Stete		
Baltimo	_	21. Signature of Funeral Service Licer			22. Na	ame end Addre	ss of Fecility	- 1					
B E E	og .	State Anatomy Board 655 W. Baltimore Street											
		Baltimore, MD 21201											
Dhualala		Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Due to (or es e consequence of): Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Due to (or es e consequence of):										Interval Between Onset and Death	
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P.O.	ysi	Part II. Other significant conditions of						Id tobacco use contribute to the cause of death?					
P.O. the the detache	4	Alzhermers o					1 Yes 2 No 3 Probably 4 Unknown						
DIVISION OF VITAL RECORDS, P.O. BOY I or Attending Physician: The law requires that the death ca after death. Director: After this certificate has been signed by the strengt in by the funeral director; page 2 should be detached for us ertification: To Be Completed by Physician/	Completed by Physician/	Alzhermers disease Diabetes mellitus				24a.				orformed? available		ore autopsy findings aitable prior to impletion of cause	
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Of Vital Rephysician: The lever this certificate has religiously discontinuous el director, page 2		25. Wes case referred to medical				1 Yes 2 No 1 Yes 2						1 195 2 100	
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ro the fo the	Me	29b. Signatura and titte of certifier						9d. Date signed (Month, Day, Year)					
- 3 - 0		Dilwear.			D 358 44				October 05, 2000				
		30. Neme and addrawn of person who) (Type, Prin	(Type, Print)									
		DRoygen 5	401 old C	ourt	Road	Run	dalls	Town 1	MD	2113.	3		
Regi:	State strar	31. Dete filed (Month, Day, Year) DCT 1 2 21	32. Registrar's	Signatura	A	Som	Pa.						



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State of Maryland / Department of Health and Mental Hygiene 00 32145

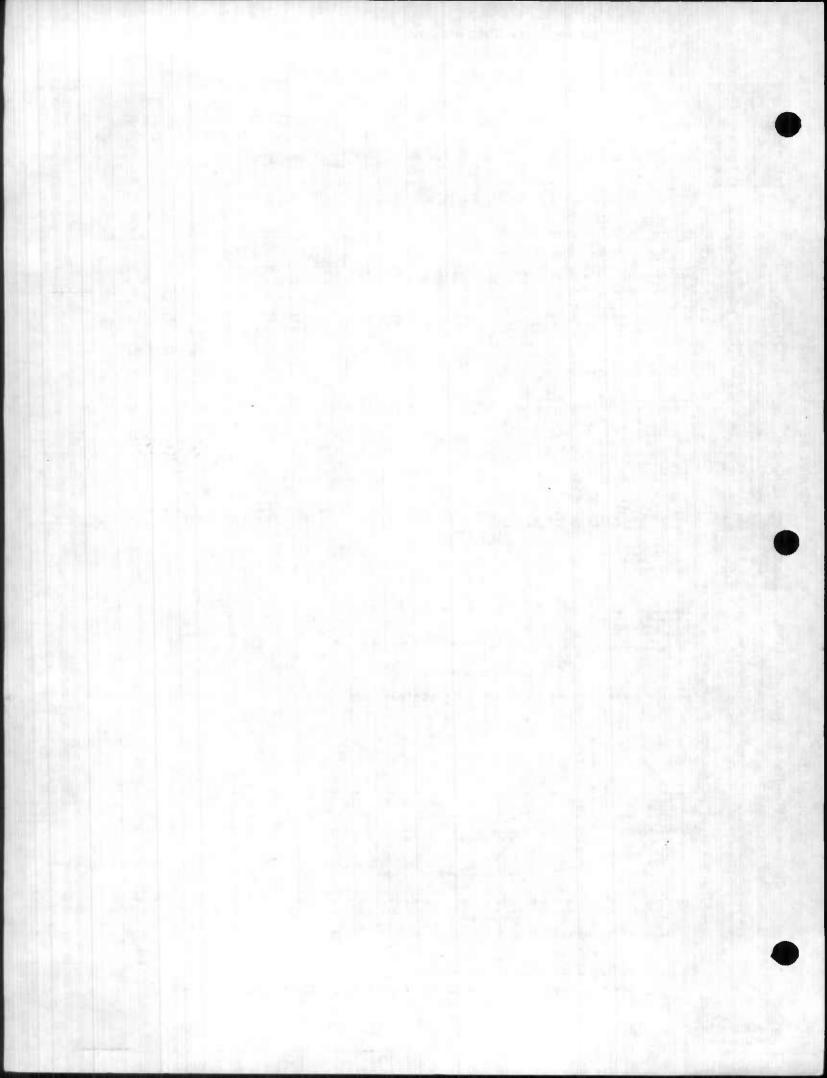
						Ce	rtificate	of L	Death		Reg. No.		2170
	Physicia		1. Decedent's Nama (First, Middla, La	charle	es R.	Lowe				2. Data of De Month	Day	Yaar 2000	3. Time of Death 5:25 A.M
	/Medica Examine	-	4a Facility Name (If not institution, giv FRANKLIN SQUARE	1	TAL C	ENTER		4	b. City, Town, or L KOSE I		h 4c. Coun	y of Death	
	Funeral Director		5. Social Security Number 6. S 214-30-2983	ex 7. □xM 2□ F	Age (In yrs.	last birthdey Yrs.	If Under Months	1 Yaar Days	Hours Min.	8. Date of Bir (Month, De Feb. 2			place (Stete or Foreign ntry) York
Me Managaran	ef ahow	tor	10a. State 10b. County	Baltimore		ty, Town or L	ocation		Dunda	alk		1	0d. Insida City Limits 1 ☐ Yas 2 ☑ No
-	8	al Director	10e. Street and Number 1940 Frames Road	1		Mal	10f. Zip (Code	21222		10g. Citizen of		
020	al', or flora	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Force Varyes 2 If Yes, Give Year or Date	es?		Was Decede If Yes, speci 1 ☐ Yas 2		spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, atc.)	Spec		
15-0	natur	eted	15. Decedent's Ed (Specify only highest gre	ducation	14.70	16a. Dece	dent's Usuel kind of work DO NOT use	k dona d	luring most of work	king	16b. Kind of		
Maryland 21215-0020	Hygiena. ther than	e Completed	Not Known 17. Fathar's Name (First, Middla, Last)	College (1-4	4or 5+)	me.	Electr		18. Mother's Nam	e (First, Middle		1 Ind	ustry
aryland ?	Mentai rked o	To Be	Winfield Lowe							y M. Bro			
, Maryla	alth and I		19e. Informant's Name/Ralationship (Mrs. Pauline L.		ife)	1	_		end Number or Rui Road Dui				222
altimore,	- I I I		20a. Method of Disposition X⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.		ate	Place of Disponental Place of	metory or oti	her plec		Date 13/2000	20c. Location		own, State er, Maryla
Baltl	Departri Importa eny inju		21. Signature of Americal Sorvice Light	Fre		2	2. Name and Duda—I	Addres		Home o:	f Dunda	lk, I	
PI	hysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that cone cause on	used the deat th line.	th. Do not er							Approximate Interval Between Onset and Death
and the same of	/Medical xaminer		tmmediete Ceuse (Finel disease or condition resulting in death)	a		static or as a conse		m (Cancer			1	12 mo
Box 68760,	ng physicia as the bur	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. MAL c		or as a conse	quence of):	<u></u>	EFFUSIO	<i>N</i>			
O. B	he atte	Physician/	Part II. Other significant conditions o	ontributing to deal	th but not ras	sulting in the	underlying ca	use give	en in Part I.	23b. Did	tobacco uee c	ontributa t	o the cause of death
S, P.O	9 0	by Phy	CHRONIC OBSTRUCTION	E PULM	ONARY	DI51	EASE			10	Yes 2 No	3 □ Pro	bably 4 Unknow
ecords	000	Completed	EMPHYSEMA							24a. Was perfe	an autopsy ormed?	6/	ere autopsy findings relieble prior to emplation of cause death?
al B	certificate h										Yes 2 No	11	☐ Yes 2☐ No
Division of Vital Records, or Attending Physician: The law requires to	this did	on: To Be	25. Was case referred to medicel examiner? 1 Yes 2 No 27. Menner of Death 1 Natural 5 Pending	Hospital: 1 1 Ing		ER/Outpatie	of 28	Bc. Injury Work	/ at	ome 5 Res			(y)
Divisio	within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide	28e. Place of	f fnjury - At h), etc. <i>(Specil</i>	ome, farm, s	M treet, factory,		Yes 2□No	28f. Location (City or To	(Street and Nur wn, State)	n <i>ber</i> or Run	el Route Number,
Hospital	24 hours E Funerel lataly filled	edical C	29a. Certifier (Check only one)		is of examina				ne, date and place, pinion, deeth occur				
	Town of A	Me	29b. Signatura and title of certifiar		M-D		29c.		number 45390		29d. Date sign		Dey, Year) h , 2000
d	XX		30. Neme and address of person who MIN CM	-		m 23a) (Type		DR.	# 206	BALT	Invoe	E, M	021237
	Stat Registra		31. Date filed (Month, Day, Year) —	32. Reg	gistrar's Signa	ature	B	Some	K.				



OCTOBER 6, 2000 12:30 a.m.	Baltimore, Maryland 21215-0020
6,	ore,
OCTOBER	Baltim
LANIER	Records, P.O. Box 68760,
LDINE LANIE	Record

		AM	END#14 PER F	.H. G78				artment rtificate			and M	ental Hyg	giene	0	321	46
	Dhuaisian		cedent's Name (First	, Middle, La		130						2. Dete of Dee Month	th Dev.	Year		of Death
	Physician /Medical		GERALDINE		(NMN)		L	ANIER					6, ^{Dey} 2000		12	2:30am
	Examiner		acility Name (If not in: STELLA MAR	IS HO	SPICE					DULA	NEY	VALLEY		TIMO		
	Funeral Director	2	ciel Security Number 226-40-992 Il Residence of Deced		Sex IDM 2\sum F	68 Age (In yrs.	last birthdey) Yrs.	If Under Months	Deys	If Under : Hours	Min,	8. Dele of Birth (Month, Day NOV • I	1 ^{Year)} 1931	9. Birthp	Jece (Stet	e or Foreign
	f show ed at	10a.		County			y, Town or Lo					*		1		City Limits
	deeth with the Maryland ms 23a or 28a-f show must be notified at	10a.	Street and Number	OOD R	OAD	Dit		10f. Zip	Code	2123	9		10g. Citizen of V	What Cour	ntry?	
	fler deeth v	11. N	laritel Sietus	002	12. Wes Deced	dent Ever in U	,S. 13.	Wes Decede	ent of H			cify Yes or No- Rican, etc.)	14. Rec		an Indien,	
020	urs efter	3	□ Never Merried 2[□ Widowed 4 💆 Di		Armed Ford 1 Yes 2 If Yes, Give Yeer or De	XNO		If Yes, speci		Specify:	, Puerto I	Rican, etc.)	Specify	ck, White,	etc. WHI BLAC	
Maryland 21215-0020	within then then	Ele	15. De (Specify only ementery/Secondery (12	-	ducation ade completed) College (1-	4or 5+)		dent's Usue kind of work DO NOT use NICIAL		etion during most t)	t of workin	ng	16b. Kind of Bu			
land	ontal H ced out ceven	17. F	ether's Neme (First, A ELIJAH	Aiddle, Last,)	SH	INE			18. Mothe	cora Cora		Maiden Sumen LEE	10)	JE	ENKINS
ary	2 should be ond Mile mark		Informent's Name/Re	letionship (Type, Print)		19b. Maili	ing Address	(Street	en <i>d Numbe</i>	er or Rura	l Route Numbe	r, City or Town,	Stete, Zip	Code)	
	1 end 2 Health em 27 i	1	MARIA HOLM	AN (D.	AUGHTER)					RD.,	PAR		MD 212			
ore	or oth		Method of Disposition I X Buriel 2 ☐ Crem		Removel from S	1010	emetery, cre	metory or of	her pled	(e)		Dete	20c. Location -			
Ë	ment: lury	4	Donation 5 0	ther (Specif	ý)	LO	UDON P					0/10/00	BALTIM	IORE,	MAKY	(LAND
Baltimore,	permit. Pages 1 er Department of Heal Important: if Nem 2 any injury or other pince.	21. 9	Signeture of Funerel S	ervice Licer	1500				N PA	RK FU	INERA	L HOME	ORE. MI	212	29	
		23a	Part Enter the dise hock, or heert feilur	ese, or com e. List only	plications that ca	used the deel	h. Do not en	ter the mode	of dyln	g, such as	cardiac o	r respiretory er	rest,		Approxim Intervel & Onset er	Between
	Physician /Medical Examiner	resu	ediete Cause (Final ase or condition iting in death)		e. GAS		CANCER or es a conse	quence of):						1	011301 01	II Deall
x 68760,	ca burge	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of):														
Вох	for for			Atal								OOL DIE		1	- ab	
P.O.	that the death certificated by the attending phy detached for use as the Physician/Medi		I. Other elgnificant c	onditions o	contributing to dea	ath but not res	ulting in the u	underlying ca	ause giv	en in Pert I			obacco use co Yes 2□ No			
Records,	The lew requires that alse has been signed page 2 should be del											24e. Wes	en eutopsy med?	av	ere eutop eilable pri empletion death?	
<u>m</u>	The lew ata has page 2											101	es 2 X No	1	☐ Yes 2	2□ No
Ita	C = 5 6	25. V	Ves case referred to rexeminer?	nedical					100			(Check only o				
n of	ng Phys fler this ineral di	1	Yes 2 No fenner of Deeth Naturel 5	Pending	28e. Dete o (Month	patient 2 [28b. Time of Injury	of 2	8c. Injur Wor	y at k?	1		lenca 6 101th now injury occur		h) HO	SPICE
Division of Vital	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	3	Suicide 6	investigatio Could not b determined	e 28e. Pleca	of Injury - At h g, etc. (Specia	ome, ferm, st	M reet, factory		Yes 2 🗆		28f. Location (S City or Tox	Street and Numi m, State)	ber or Rur	el Route A	lumber,
	Ne Hospital n 24 hours Ne Funerel pletely filled				nysician: To the bar niner: On the bar end menn	sis of examine										se(s)
	Somp N		Signeture and little of	Cortifier /	-			290		e number			29d. Date signe	6/6/c		r)
	con	30. N	lame and address of p	person who	completed cause	of deeth (Iter	n 23e) (Type	, Print)				12 1				
	AR		DR. TARIQ		1	O DULA		LLEY F	D.	TIMO	NIUM	, MD 21	093			
	State	31. 🖸	ate filed (Month, Dey			gistrar's Sign	eture	-	-							
	Registrar		OCT 1	2 200	0	never	1	100	de							

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** THOMAS MCKENNA 12:48 PM OCTOBER 10, JAMES 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY 3515 HARFORD ROAD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** Days 12 M 2 F 215-09-6698 89 DECEMBER 23 1910 MARYLAND Director Usual Residenca of Decedent 10c, City, Town or Location 10e State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at the Maryle BALTIMORE MARYLAND 1 1 Yes 2 □ No N/A Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES OF AMERICA 21218 3515 HARFORD KOAD Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. "natural", or items 11 Marital Status 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Be Compieted 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 16b. Kind of Business/Industry tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) STATE OF MARYLAND AUDITOR NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Peges 1 end 2 should be fill ment of Health end Mental Hant: if item 27 is marked oth lury or other traumatic even J. MCKENNA BERNARD MARY A. DORSEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 3515 HARFORD ROAD / BALTIMORE, MARYLAND 21218 URITH E. MCKENNA 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date OCT. 14 200 BALTIMORE, MARYLAND 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any Injury or BALTIMORE CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 6009 HARFORD ROAD Gonald R. Watson, J. # MOD612 ALTENBURG FUNERAL HOME, P.A. BALTIMORE, MD. 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** 2 days Bronchopneumonia /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner sician end buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physician s the buriel Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequenca of): 98 esn Ö 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown COLON CANCER OF THE signed b 29 24b. Were autopsy findings available prior to completion of cause of death? Completed CORONARY ARTERY 24a. Was an eutopsy DISEASE pege 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificete funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Dev Year) 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Matural 5 Pending efter deeth. Director: Aft 1 Yes 2 No investigation 2 ☐ Accident 3 ☐ Suicide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner utated. 29a. Cartifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertilier 29c. License number D0015462.

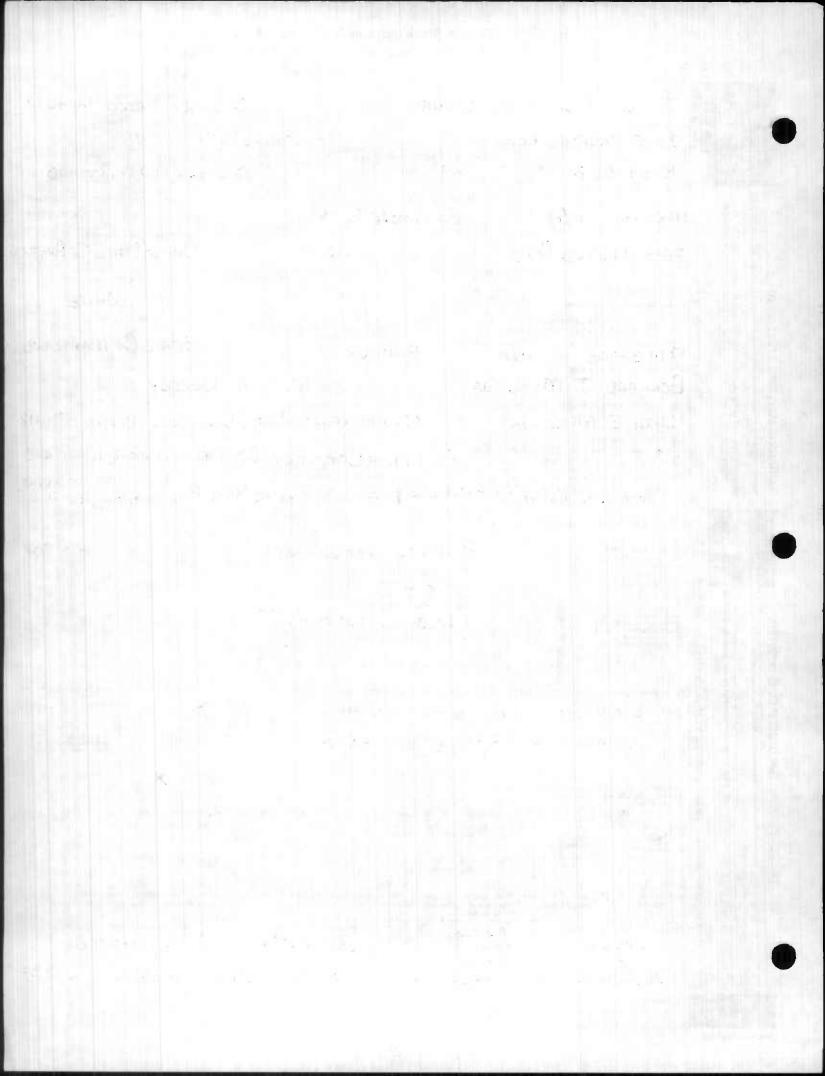
Registrar

31. Date filed (Month, Day, Year)

OCT 1 2 2000

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 E. 331 LST #640 BALTO MD. 21218

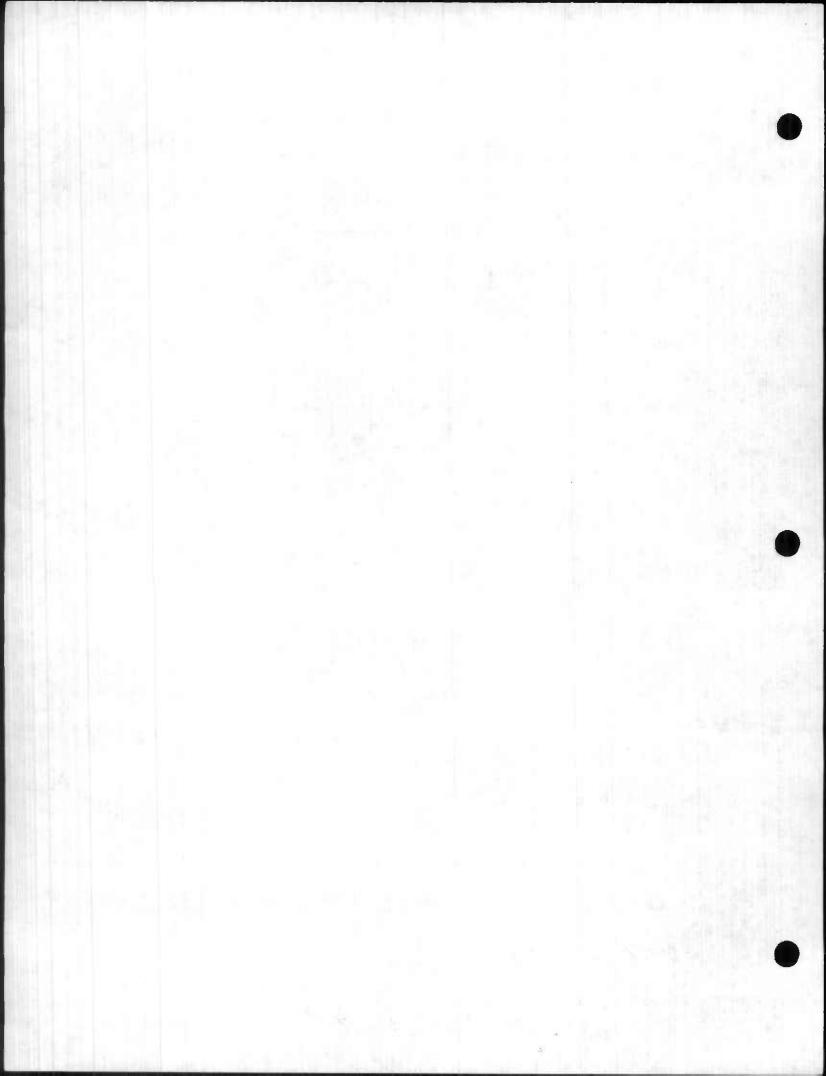


Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0000

		HE W	Ce	rtificate of	Death	R	eg. No.	32140					
Physician	Decedent's Name (First, Middle, Last					2. Dete of Dea Month	Day Y	3. Time of Death					
/Medical	DAVID FRANKL	IN MYERS				OCTOBE	R 9, 200	0 15:28 PM					
Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death	4c. County of	Death					
	HARBOR HOSPITAL				BALTIN		n,						
Funeral Director	5. Sociel Security Number 6. S. 220–20–9592 Usuel Residence of Decedent	B	71 Yrs. last birthday)	If Under 1 Yee Months Days				h. Birthplace (State or Foreign Country) Maryland					
pue *_	10a. Stete 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits					
the Meryler 28a-f ahow northed rector	Md. n/a		Baltimor					1X Yes 2□ No					
J firer deeth with the Me r ferms 23a or 28e-fa sing must be norified funeral Director	10e. Street and Number 23 E. West Street	et		10f. Zip Code	21230		Og. Citizen of Wh						
urs sur.	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? ↑ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☐ No	ben, Mexicen, Pue	Specify Yes or No- to Rican, etc.)	14. Haca - Black, Specify:	American Indian, White, etc. White					
"netural", nd call En	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occu	upation e during most of wo	ackina	16b. Kind of Busin	ness/Industry					
within then then	(Specify only highest gra Elementery/Secondery (0-12)	College (1-4or 5+)		Driver	ed)	nking	Transpo	ortation					
be filed tal Hygid d other bevent, the	17. Fether's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumeme)						
yian build be Mental Mental Mental Mental Mental Mental To B	Harry Myers				Hele	n Mildred	Marhefk	'a					
Tarylar Tarylar 2 should be end Menta Is merked surretic ex	19e. Informant's Name/Relationship	vpe. Print)	19b. Maili	na Address (Stree		tural Route Number							
Maryland d 2 ahould be file th end Mental Hy 7 is marked othe traumatic event	Nina Scheppske	(Niece)				e, Baltim							
Ore, N	20a. Method of Disposition		20b. Place of Dispo	sition (Neme of									
0 80 = 5	1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 10/13/2000 Baltimore, Md.												
Daltim permit. Pac Departmen Important: any Injury pince.	21. Signature of Fuperal Survey icensee Kevin E. Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home P												
Physician /Medical Examiner	Immediate Cause (Final diseese or condition resulting In deeth)	a. Arteriosc	lerotic (scular Di	isease							
BOX 08/00, eath cartificate be executed etending physician end for use as the buriel-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Due to (or as e consequenca of): Due to (or as e consequenca of):												
death car death car death car death car	De a tradition de la litera de la constitución de l		and the second second	40.4.40.00.000	t on to Book!	ook Black		the sea sea show a reason and all restrict					
that the death careed by the ettending detached for use	Part II. Other significant conditions or	entributing to death but no	ot resulting in the u	ndenying cause g	Iven in Part I.	23b. Did tobacco usa contribute to the cause of							
Vital Records, P.O. Box uldan: The law requires that the death carl certificate has been signed by the ettending rector, page 2 should be detached for use Be Completed by Physician/M						24e. Was e perfor	med?	24b. Were eutopsy findings available prior to completion of cause of deeth?					
o C. p	25. Was case referred to medical				26 Place of De	ath (Check only or		/-					
Of Vital Physician: this certific ral director,	examiner? 1 X Yes 2 No	Hospital: 1 ☐ Inpatient	Ž O ER/Outpatie	nt 3D DOA	ther:	Home 5 ☐ Resid		(Specify)					
ng Ph fter th ineral	27. Manner of Death 1 ⊠Naturel 5 □ Pending	28a. Date of Injury (Month, Day Ye		f 28c. Inj		4	ow injury occurred						
Division of To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director of Medical Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, st Specify)			28f. Location (S City or Tow		or Rural Route Number,					
Ne Hospita n 24 hours ne Funeral pletely filled		yalcian: To the best of m iner: On the basis of exa and menner steted	amination end/or in										
o the	29b. Signeture and title of certifier		Fig. 15.	29c. Licer	nse number		29d. Date signed	(Month, Day, Year)					
F 3 F 0	111	111.		12 ,477	0 0 11 -		0	mm 10 0000					
DXI	20 Name and address of the	M. C. B	Man 220 Time	Print)	O.C.M.E.		OCTOB:	ER 10, 2000					
311	30. Name and address of person who of Theodore King M.D.		111 Per	nn Stree		nore, Mar	yland 21	201					
State Registrar	31. Date filed (Month, Day Year)	32. Registrer's	Signature Epither	13 4	parts								

DHMH 16 Ray 6/95



Physician

/Medical

Examiner

Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours effer death with the Meryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or herm 23a or 28a-f ahow any injury or other traumatic event, the Medical Experience man be notified at excess.

Baltlmore, Maryland 21215-0020

To Be Completed by Funeral Director

Pleas	se Type or State o	Print In I								gible.	
			Ce	rtificat	e of I	Death			Reg. No.	U	32149
1. Decedent's Name (First, Middle, Henry F. Matthi								2. Date of Do Month OCTOBE	Dey	Yeer 2000	3. Time of Death 6:00 P.M.
4a Facility Name (If not institution, 5801 George Is)	-				4	Stock		ocation of Dear	th 4c. Cou	en An	th
216-03-5390	6. Sex 1X M 2□ F	7. Age (In yrs. 8.	5. last birthday) 5. Yrs.	Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di Jan. 1	rth ay, Year) 1, 191	Co	thplace (State or Foreign buntry) MD
Usual Residence of Decedent 10a. State 10b. County MD Queer	n Anne's		ity, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
10e. Street and Number 5801 George Isl	37			10f. Zip	Code				10g. Citizen		untry?
11. Maritel Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	Armed Fo	2√ No ive No		Was Deced If Yes, spec	10	lispanic Ori an, Mexican Specify:		ecify Yes or N Rican, etc.)	0- 14. F E Spe	leck, Whit	orican Indian, e, etc. White
15. Decedent's (Specify only highest Elementary/Secondary (0-12)			(Give	edent's Usua kind of wo DO NOT us	ork done d ise retired	during most	t of work	ing	16b. Kind of	Business	Industry
9 17. Fether's Ne <i>me (First, Middle, L</i> Frederick Matt	ast)		Sel	if en	ploy	18. Mothe		e (First, Middle	Un , Maiden Surr Ine	eme)	
19a. Informant's Name/Reletionshi Wayne Matthiese	ip (Type, Print)					and Numbe	er or Rura	al Route Numb	ber, City or Too		?ip Code)
20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of the Control	ecify)	State	Plece of Dispo cametery, cree keview	Cemet	tery			Date 0-11-00			Town, State
21. Signature of Funeral Service Li 23th Part Ferter the disease, one shock, or heart failure. List of	Aus	fausod en cias each line.	Am 13	328 St	e Fur ulphu	neral ur Spi	Home ring		butus,	MD.	21227 Approximate Intervel Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a(Chr. Due to ((or as a consect	quence of):	,6	0	0	-1.0	7		C M.
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b	Due fo (or as a conseq	quence of):				1 + **			
	d										
Pert II. Other eignificant condition	is contributing to do	eath but not res	sulting in the u	Inderlying c	ause give	en in Part I	n 4	7.00	Yes 2 N		to the cause of death?
Chamica	uses	esl						24a. Was	s an autopsy ormed?		Were autopsy findings evailable prior to completion of cause of death?
						a F		10	Yes 2X No		1 ☐ Yes 2 No
25. Was case referred to medical examiner?	Hospitel:				Oth	or:		h (Check only			
1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending 2 Accident Investiga	28a. Date (Mont		28b. Time of Injury		28c. Injury Work	AW'I IAR			how injury oc		cify)
2 Accident Investigated Suicide 6 Could not determine	et be	e of Injury - At h	nome, ferm, str					28f. Location	(Street and Nu	mber or R	ural Route Number,

The lew requires that the deeth certificeta be exec Division of Vital Records, P.O. Box 68760,

Physician

/Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

29b. Signeture and title of certifier

within 24 hours eftar death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician:

> State Registrar

DHMH 16 Rev 6/95

DR. FEDERICO ARTHES, 31. Date filed (Month, Day-Year) 32. Registrar's Signature OCT 1 2 2000

30. Name and eddress of person who completed cause of death (Item 23ar (Type, Print)





12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) end manner es steted.

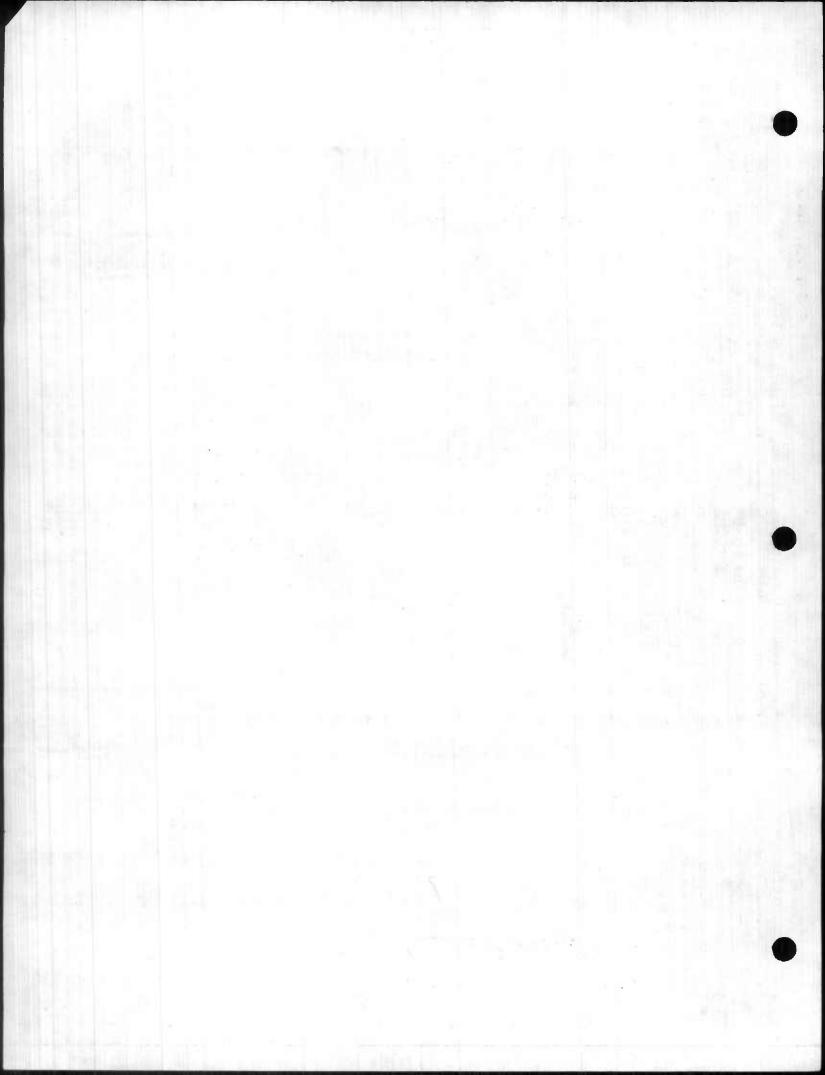
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

D02026

29d. Date signed (Month, Day, Year)

2001

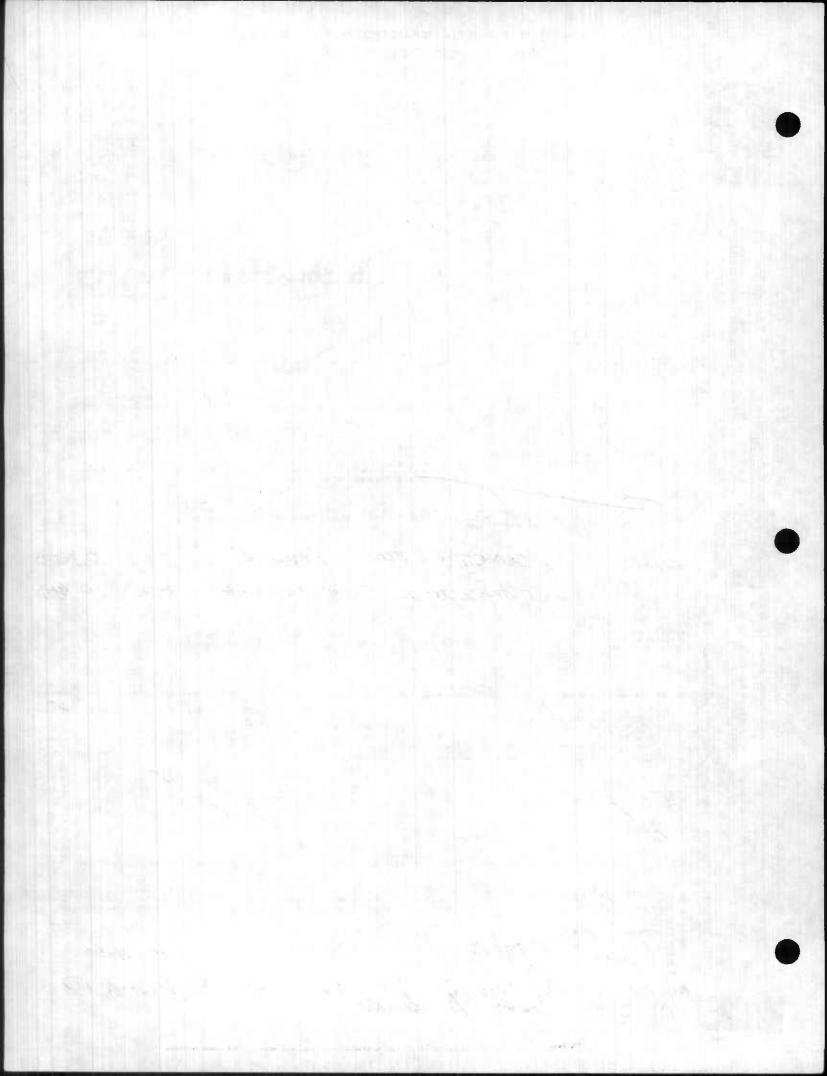


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State of Maryland / Department of Health and Mental Hygiene

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00	321	C

				Cer	tificate of	Death		Reg. No.		
Physician /Medical	Decedent's Name (First, Middle, L HUGO	L.	MA	TTHE	ISS		2. Dete of D Month OCTOB	ER 11,	Year 2000	3. Time of Death 9:35 A.M
Examiner	4e Facility Neme (# not institution, gr 1911 REDWOOD AV		er)			4b. City, Town, PARKV	or Location of Dee		of Death	Ε
Funeral Director	212-07-1128	Sex 125 M 2□ F	Age (In yrs. lest	birthdey) Yrs.	If Under 1 Yeer Months Deys		Hrs. 8. Dete of B (Month, L) 12/5/	irth Pay, Year) '08		aca (Stete or Foreign ry) TLAND
B &	Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, To	own or Loc	cation				10	Od. Inside City Limits
outh the Maryl or 28s-1 sho be notified a	MD BALTIM 10e, Street end Number	ORE	PAR	KVILL	E 10f. Zip Code			10g. Citizen of	What Count	1 ☐ Yes 2√ No
	1911 REDWOOD AV	ENLE			2123	34		US		.,,,
her death v r herre 23s siner must	11. Meritai Stetus	12. Was Deceder		13. V			? (Specify Yes or Nuerto Rican, etc.)		e - America	
Dy by	1 Never Merried 2 Married 3 XWidowed 4 Divorced	Armed Forces 1 X Yes 2 If Yes, Give Yeer or Detes	No		☐ Yes 2 No		ueno Hican, etc.)		ok, White, o	
5-0 72 ho 72 ho scal	15. Decedent's E	ducation	10	Se. Deced	ent's Usuei Occup	pation during most of	working	16b. Kind of B	usiness/Ind	ustry
1 21215-0 ad within 72 ho ygiene. In then 'ristum I, the Medical.	Elementery/Secondery (0-12)	Coilege (1-4o	or 5+)	life. D	OO NOT use retire	od)				
	17. Father's Neme (First, Middle, Las	(4)		MACE	INIST	18 Mother's	Neme (First, Middle	MANUFA e Maiden Sumen		NG
Maryland 22 should be fits 12 should be fits h and Mental Hy 7 is marked other treumetic event	WILLIAM H. MATTH	EISS				CARO	LYN BESSI	ER		
March and Tris m	19a. Informent's Name/Reletionship						r Rural Route Num			
Te, 1 and Hoat 2	CHARLES MATTHEIS 20e. Method of Disposition	5	SON 20b. Piece	of Dispos	REDWOOI		Date	ILLE, MD		
altimore mit. Pages 1: partment of No portant: if New y Injury or oth	1 🖾 Burial 2 Cremation 3 4 Donetion 5 Other (Spec	ity)	10	LAND	MEM. PAF	RK	10/14/00	HILLEN	DALE,	MD
Ball Ball Ball Ball Ball Ball Ball Ball	21. Signeture of Funerel Service Lice	ensee			Name end Addre		RAL HOME	, P.A.		
	236 Pert1. Enter the disease, or cor shock, or heart feiture. List only			8	521 LOCH	RAVEN	BLVD. TY	OWSON MI	21:	286 Approximete
Physician /Medical Examiner	Immediate Ceuse (Finei diseese or condition resulting in deeth)	o. CONG	Due to (or es	e conseq	uence of):	FAIL	CHE	\$ 5500		8 YEARS
Ox 68760, n certificate be executed anding physician and use as the bunal-transit an/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initieted events resulting in death) Last	c	Due to (or es	e consequ	uence of):					7.011/2
P.O. Bo net the death of d by the etten letached for u Physician	Pert II. Other algnificant conditions	contributing to death	but not resulting	g in the un	derlying cause gi	iven in Pert I.	23b. DI	d tobacco use co	ntribute to	the cause of death?
n = 00							10	Yes 2 No	3 Prot	bably 4 Tunknow
requirements should							24a. We	s an eutopsy formed?	eva cor	ore eutopsy findings allable prior to appletion of cause deeth?
I Rec							10	Yes 200 No	10	Yes 2 No
f Vital Pysician: The secretificate director, pag	25. Wes case referred to medical examiner?					26. Plece of	Deeth (Check only	one)		
of Vita Physician: this certific ral director, TO Be	1□ Yes 2⊡ No	Hospitei: 1 🗆 Inpa		Outpetien	3LI DOA	her: 4 Nursi	-	sidenca 6 Oth)
After fune	27. Menner of Deeth 1 Naturet 5 Pending 2 Accident investigation		Dey Year) 28	o. Time of Injury	M 1	iryet ork?]Yes 2 ☐ No		e how injury occur	red	
Division or Attending s after death. d Director: After d in by the fune Certification	3 Suicide 6 Could not	200. PIECE OF I	injury - At home etc. (Specify)	, farm, stre	eet, fectory, office			(Street end Numi own, Stete)	ber or Rure	l Route Number,
Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After toomplately filled in by the funeral Medical Certification:		hysician: To the besiminer: On the basis end mennific	of examinetion							
To the To the comple										
	- Clasel	- 1 xp 1	NO		D.	31189		10	-11-	00
641	30. Neme and address of person who	completed cause of	death (ttem 23	a) (Type, I	Print) 813 Was	Offers	Looss	D, bra	ob xer	MO
State	31. Date filed (Month, Day Year)	Denes Benis	strar's Stanature	100	eks/			1	-1	



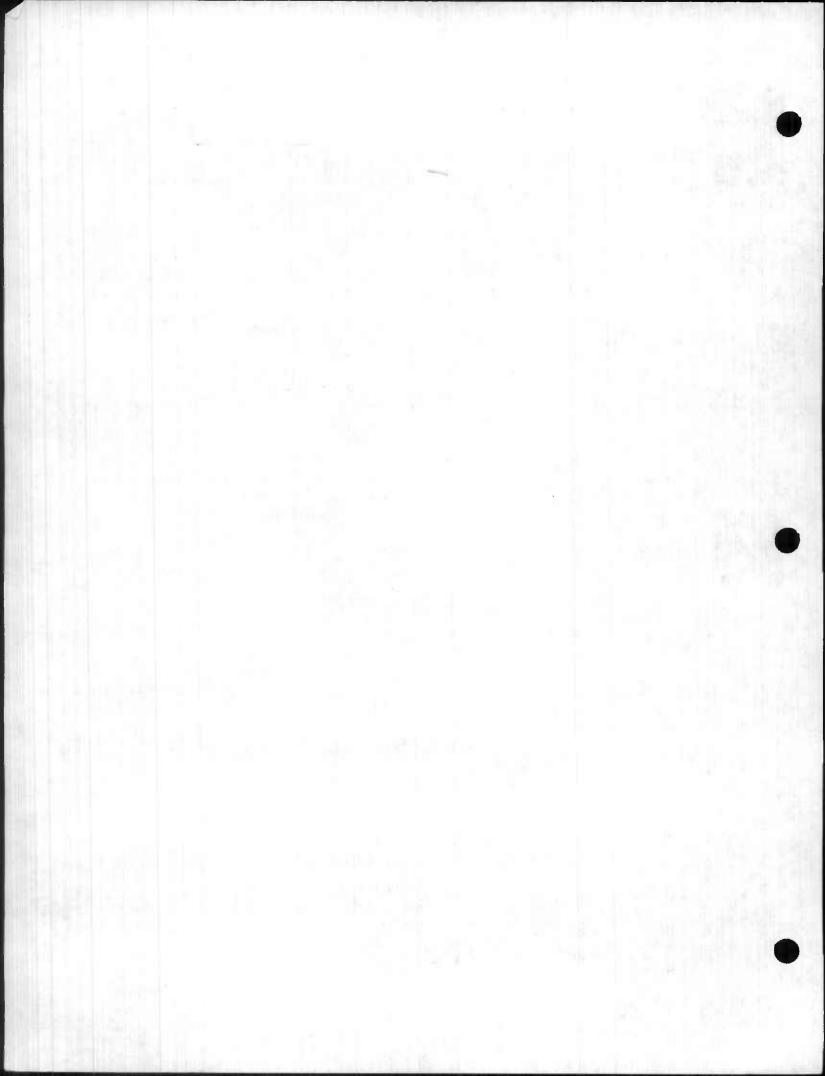
State Registrar MARY G. RIPPLE, M.D.

31. Date filed (Month, Day, Yeer) 2000 32. Régistrar's Signature

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

5. Aparks

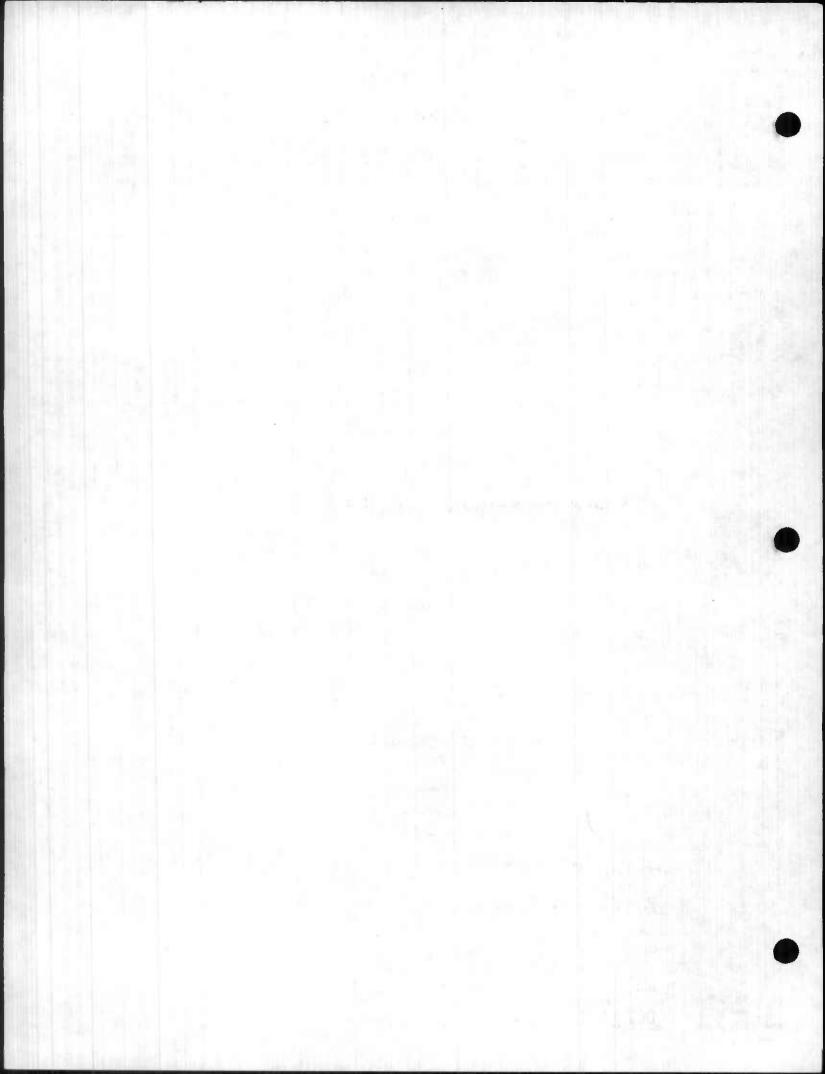


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State of Maryland / Department of Health and Mental Hygiene 0 0 32152

.y M	lorgan					Ce	rtifica	te of i	Death			Reg. No.			
		1. Decedent's Nama	(First, Middle, La	est)							2. Data of De Month	eath Day	Yaar	3. Tima of Death	
	Physician /Medical	Sh	erry		Moi	gan					Octobe		000	11:03 A.M.	
	Examiner	4a Facility Nama (III	not Institution, gi			3		- 4			cation of Deal	th 4c. Count	y of Death	TITOU CONTIN	
		4400 F1	ranconia	Road					Balt:	imore	9	N	I/A		
	Funeral	5. Social Security Nur		Sex	7. Aga (In yrs	. last birthday)	If Unde Months	T 1 Yaar Days	If Undar Hours	24 Hrs. Min.	8. Data of Bi (Month, D	rth ev. Year)	9. Birth	place (State or Foreign ntry)	
	Director	215-84-	8824	¹□M 2□F	27	Yrs.	Working	Duyo	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	12-23	-72		MD	
P		Usual Rasidence of D	Decedent			11a							1		
72 hours after deeth with the Mervland	al, or Nems 23s or 28s-f show Examiner must be notified at by Funeral Director		10b. County		106. 0	ity, Town or Lo								10d. Inside City Limits 1 ☐ Yas 2 ②No	
M e	cto and	MD	Baltim	ore		Ess	ex								
4	or 28a-f s be notified Director	10e. Street and Numi						p Coda				10g. Citizen of What Country?			
*	23.0	702 Sno	wberry	Court	Apt.	3	21	.221				USA			
r dee	r Nems 23a Alber must Funeral	11. Marital Status		12. Was Dec Armed F	cedent Evar in orcas?	U,S. 13.	Was Dece	dent of H	ispanic Ori	igin? (Spin, Puarto	ecify Yas or N Rican, atc.)	0- 14. Ra Bl	ce - Amari ack, Whita,	cen Indian, , atc.	
d within 72 hours afte	A DE			If Yes, G	2 No		1 ☐ Yas		Specify:				ity: DI a	ale	
OUCS	France, o	3 ☐ Widowed 4	Divorced	Yaar or I	Datas:			A					b Bla	ick	
72 h	ygiene. or than "natural", rt, me Medical Exa Completed by	(Specifi	15. Decedant's E	ducetion ade completed)	16a. Dece (Give	dent's Usu kind of w	al Occup	ation duning mos d)	t of work	ing	16b. Kind of I	Businass/Ir	ndustry	
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8	doth Went	17. Fathar's Nama (F									a (First, Middle	, Maiden Suma			
should	marked other than marked other than matic avent, pre M	Gregory		Morga	ın				Loi			Flemi		03.000	
2 sh	th and Mar 7 is marks traumatic TO	19a. Intormant's Nan												p Code) 21,223	
end	= 0 F	Lois	Flem	ing						Str				Ltimore, MI	
98 1	If item 2 or other	20a. Mathod of Dispo			20b.	Place of Dispo cemetery, cres	nsition (Na metory or	me of other place	ce)		Data	20c. Location	- City or T	own, State	
Pedes	int: If	4 Donation 5				oodlaw	n Ce	emet	erv	10-	16-200	O Wood	llawr	n, MD.	
permit.	Department of Important: If any Injury or police.	21. Signatura of Fund	aral Sarvice Lice	nsee					ss ot Facili	tv		more, Maryland 2120			
Ded	Dep imb	1 40	. 0												
		23a Part1 Fotar tha	disassa or con	nolications that	caused the day	ath. Do not an	M . C	Mar da of dvir	CD E	cerdiac	or raspiratory	North	AVE	Approximate	
ъ.		23a. Part1. Entar tha shock, or haart	failura. List only											Interval Batween Onset end Death	
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	xaminer	disaasa or condition rasulting in death)		a	and Asphyxiation										
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per	in end rial-trensit Examiner	b													
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ertificate be executed	ding physicisse as the bu	rasulting in daath) La	ast		Dua to	or as a consac	quanca ot)	:							
certif	attending ph of for use es the			d											
death	d by the attendeteched for us														
the de	ed by the deteched	Part II. Other eignific	ant conditions	contributing to d	daath but not re	sulting In tha u	inderlying	causa giv	an in Part	l.	23b. Dic	i tobacco use o		to the cause of death?	
thet th	P deby										1	Yes 2X No	3□ Pro	obably 4 Unknown	
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we	2 2 5			THE LE										f death?	
The	page page										15	Yas 2□No	1	Yas 2□ No	
	certificate rector, pag	25. Was cesa ratarre	d to medicel						26. Plac	a of Deat	h (Check only	one)			
Physician:	To E	axaminar? X Yas 2 N	lo	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 D	OA Oth	ar: 4 N	ursing Ho	me 5□Ras	sidance 6 XIO	thar (Spec	ity) at scene	
	er th	27. Manner ot Death		28a. Data	ot Injury oth, Dey Year)	28b. Tima o	of	28c. Injur Wor	y at		28d. Dascribe	how injury occ	urred Su	bject was	
Idling	th. : After e funer atlon:	1 □Natural 2 □ Accident	5 Panding invastigation	n Found	:	Found:	M		Yas 20	No	beaten	, stabb	ed, c	cut, and	
Attending	rs after death. al Director: After t led in by the funere Certification:	3 ☐ Suicide	6 Could not 1	28a. Plac	7-2000 e of Injury - At	homa, tarm, st		ry, office			281. Location	(Street end Nur	nber or Ru	rel Route Number,	
ö	Direction of the brings of the	4 Homicida		build	ding, atc. (Spec	Found	: W	oods				own, Stete) Fo		4400 Ltimore, MD	
pite	S I I I I	29a. Cartifiar	☐ Certifying Pi	hvelclen: To the	a hest of my kr				ma dete er						
8	n 24 hou ne Fune pletely fil edical	(Check only 2 one)	Medical Exa	miner; On tha b	basis of axamir	nation and/or in	vastigatio	n, in my d	pinion, das	ath occur	red at tha time	, data and place	, and dua	to the cause(s)	
the	within 24 hours after deat To the Funeral Director: completely filled in by the Medical Certifical											, Day, Year)			
0	₹ F 8														
	N		30. Nama and addrass of paper who completed causa of death (Item 23e) (Type, Print)												
X	17								- 3						
5		Dennis C	hute M.I	0., 111	Penn S	treet,	Balt	imor	e, Ma	ryla	nd 2120	01			
	State	31. Data tiled (Month		32.1	Registrar's Sign	nature	1	,							
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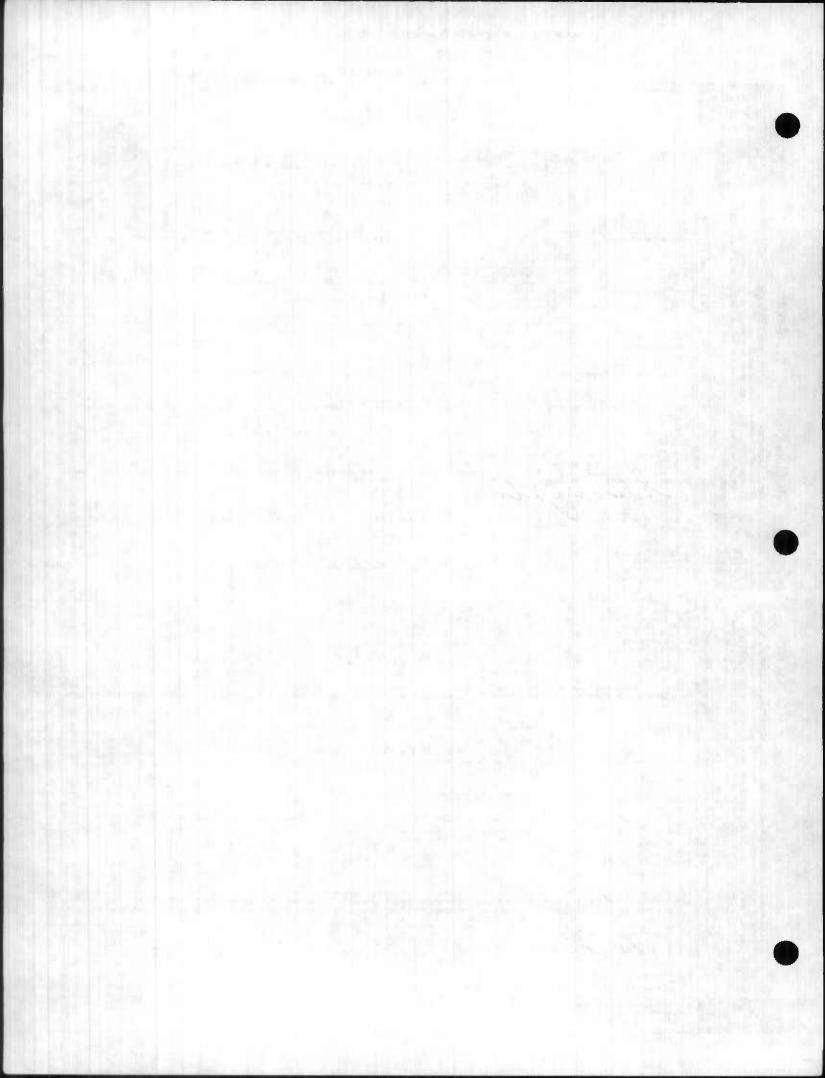
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State of Maryland / Department of Health and Mental Hygiene 32 | 53

Certificate of Death

Reg. No.

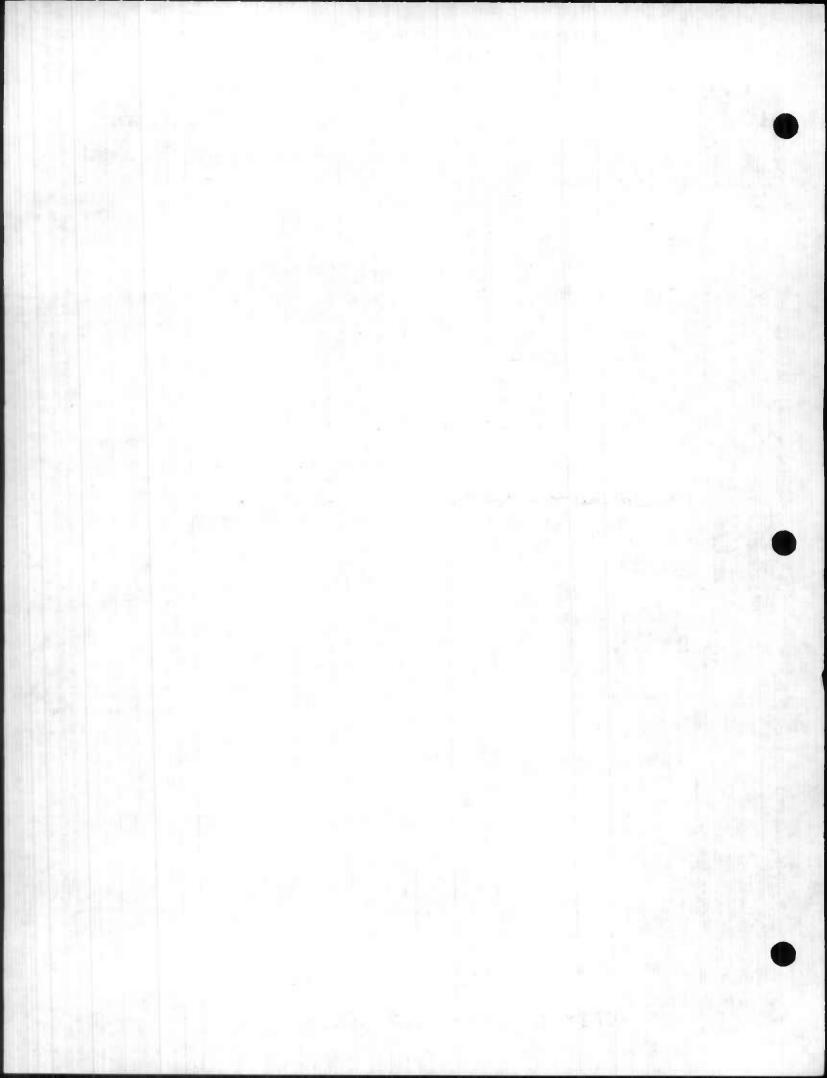
	Certificate	e of Death	Re	g. No.	
	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physician	Kathy Ann Matheson		October	9 2000	11:50 AM
/Medical	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Lo		4c. County of Deat	
Examiner	1652 Cananaro Drive	Annapolis		Anne Arur	del
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under		8 Date of Birth		hpiace (State or Fore untry)
Funeral Director	008-56-3704 1 M 2 XF 39 Yrs. Months	Days Hours Min.	(Month, Day,	1000	many
i i	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Lim
terns 23s or 25s-f short ner must be notified at uneral Director	Maryland Anne Arundel Annapolis				1 ☐ Yes 2/0
Or S	10e. Street and Number 10f. Zip	Code	10	g. Citizen of What Co	untry?
15 E	1652 Cananaro Drive 214	01	U	SA	
r teme 23 sher must Funeral	11. Marital Status 12. Was Decedent Ever in U,S. 13. Was Deced If Yes, spec	ent of Hispanic Origin? (Spoify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, White	
Examine by Fu	1 Never Married 2 Married 1 Yes 2 No	No Specify:	, 0.0.7		hite
"naturn dical i	15. Decedent's Education 16e. Decedent's Usua (Specify only highest grade completed) (Give kind of wor	k done during most of work	ing 1	6b. Kind of Business/	Industry
ygiene, ser than "natur r, the Medical. Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4 Registere			Hospita	1
100 0	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M		
Wanta irked ific ev To B	Albert G. Delude	Beverly	M. Part	1 _{OW}	
DEE		(Street and Number or Run			Tip Code)
4 2 3		aro Dr. Ann			
f Health Hem 27 other to	20a Method of Disposition 20b. Place of Disposition (Nam	e of		MD 21401 Oc. Location - City or	Town, State
# # 8	1 Burial 2 Ferenation 3 Removal from State 4 Donation 5 Other (Specify) Metro Cremato	her place)			
epartment of mportant: If my injury or fice.	21. Signature of Fusieral Service Licenses 22. Name and	Address of Facility			,
0240	Edward A. Gregorchik 299 Fr	ederick Road	Raltim	ore MD 2	1228
nding physician and see sthe burial-transit and AMedical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Methstatic Colorect Due to (or as a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Olsease or injury Cause (Olsease or injury Cause)	79 Conces			- 473
ng physicia s es the bur Medicai	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
ed for u	Part II. Other significant conditions contributing to death but not resulting in the underlying or	ause given in Part I.	23b. Did tol	bacco uss contribute	to the cause of de
ed by the attending detached for us.			1 □ Ye	8 20 No 3 P	robably 4 Unk
as been sign 2 should be			24a. Was ar perform	ied?	Were autopsy findin available prior to completion of cause of death?
pege CO			1 ☐ Ye	s 2000	1 ☐ Yes 2 ☐ No
certificate herector, page	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only on	9)	
D 0 0	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DC	A Other: 4 Nursing Ho	me 5 Reside	nca 6 Other (Spe	cify)
Te E	27. Manner of Death 1. Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	8c. Injury at Work? 1 Yes 2 No	28d. Describe ho	w injury occurred	
within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	, office	28f. Location (Sti City or Town	reet and Number or Ri , State)	ural Route Number,
n 24 hours he Funera pletely fille edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred and manner stated.				
Nethin Me	29b. Signature and title of certifier 29c	. License number	29	d. Date signed (Mont	h, Day, Year)
(1)	fallelful up	18870 (0	,c,)	10,10,	00
510	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John M. Hill, mp National Naval Wiede	had cor., Be	therda,	mo	
State Registrar	31. Date filed (Month, Day, Year) OCT 1 2, 2000 Server Signature				



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State of Maryland / Department of Health and Mental Hygiene 10 32151.

			Cer	tificate	of Death	F	Reg. No.	0210	-3			
	1. Decedent's Nama (First, Middla, Las			LANGE		2. Data of Dee	oth Day	3. Tima ot De	eath			
Physician /Medical	Bascomi W	illiam Mason	n Jr			October		00 04:35	,-			
Examiner	4a Facility Nama (If not institution, give	street and number)				r Location of Death	4c. County	ot Death	S			
	John Hopkins	Itospital			Baltin		N/A	A				
Funeral Director	214-58-5147	9X 7. Aga (in yrs	8 Yrs.	If Under 1 Y Months D	ear If Undar 24 Ho ays Hours Mi		r, Year)	Birthplace (Stata or F Country) MD.	Foraign			
p *	Usual Rasidence of Decedent 10a, Stata 10b, County	10c C	ity, Town or Lo	cation				10d. Insida City	Limits			
Maryla ef sho filed at	MD. N/A		ALTIMOR					1 ₹ Yes 2				
eath with the Maryland ne 23e or 23e-f show must be notified at er all Director	10e. Street and Number 3017 McELDERRY	ST.		101. Zip Co	da 1205		10g. Citizan ot W USA	hat Country?				
ors after of their Examiner. By Fun	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedant Ever in I Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Dates:		Was Dacedent t Yas, specify 1 ☐ Yas 2 ☐	of Hispenic Origin? Cuban, Maxican, Pus No Specify:	(Specify Yas or No- arto Rican, atc.)		- Amarican Indian, c, Whita, atc. BLACK				
72 ho	15. Decedent's Ed		16a. Deced	dant's Usual O	ccupation	vorkina	16b. Kind ot Bu	sinass/Industry				
ed within 72 hours at yglens, natural, or we than "natural, or it, the Medical Exam Completed by P	Elementary/Secondary (0-12)	Collega (1-4or 5+)	lifa. I	DO NOT usa r	ona during most of watered)	orning						
	-12-	-0-		DISABL		ama (First Middle	N/A	-1				
B state	17. Father's Nama (First, Middla, Last)					ama (First, Middla,	Maidan Sumam	a)				
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52.9) 1. 800 7.18 m	19a. Informant's Name/Relationship (7 MELINDA A. MASO				treet and Number or							
1 and 1 and 2 and	20a. Mathod of Disposition		Place of Dispo		VRE ST. B	Data Data		City or Town, State				
emit. Pages 1 i Repartment of He reportant: If them togs.	1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from Stata	cematary, cran	natory or otha	r placa)	1						
n. P. rime rtant	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funaral Service Licen	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	BUTUS M					IMORE, MARY	LAN			
Peper Peper Impo	I Swenive	e Kedo			ddrass of Facility RIN. MONROE			ICE MARYLAND 212	217			
Physician	23a. Part1. Entar the disease, or comp shock, or heart tailura. List only of	plications that caused the das one cause on each line.	ith. Do not ant	ar tha moda o	f dying, such as card	iac or raspiratory ar	rast,	Approximata Intarval Batwe Onsat and Da	een aath			
/Medical Examiner	Immediata Causa (Final diseasa or condition rasulting in death)	a. signet ce	11 carci	noma	of the b	ladder	400	6 mon	Ms			
5			(or as a consec									
mln		b										
cate be executed physician and sthe buriel-transit	Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Ceuse (Disease or injury that initiated events	nditions, Dua to (or as a consequanca of):										
ficate be physicians the burn edical	Ceuse (Disease or injury that initiated events	C. Due to /	or as a conseq	nauca ot).								
5 0 6	rasulting in death) Last		or as a conseq	danoa osy.								
endir r use		d										
ed fo	Part II. Other significant conditions co	ontributing to death but not ra	sulting in tha u	ndarlying caus	a givan in Part I.	23b. Did 1	obacco use cor	tribute to the cause of	death			
ires that the deeth certification of the strending does deteched for use a deeth of the physician/M	Acute on C	hronic Ren	al Fai	lure	131	10	Y●● 2□No	3 □ Probably 4 ☑ 4 I	nknow			
requision shoul	Urinary To	act Infects	o n			24a. Was perfo	an autopsy rmed?	24b. Wara autopsy tind available prior to completion of cau of death?				
he lew te hes age 2						101	ras 2 No	1 □ Yas 2KIN	No.			
	25. Wes casa refarred to medical				26. Placa of D	Death (Check only o	na)					
Physician: rthis certificanal director, rthis Certificanal director,	axaminar? 1 ☐ Yas 2 ☒ No	Hospital:	☐ ER/Outpatier	nt 3 DOA	Other:	Homa 5□ Rasio		ar (Specify)				
	27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of		Injury at Work?		now injury occurr					
To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	1 Natural 5 Pending 2 Accident invastigation 3 Suicide 6 Could not be 4 Homicide detarmined		homa, tarm, str	М	1 ☐ Yas 2 ☐ No	28t. Location (S		er or Rural Routa Numbe	er,			
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificat	(Check only 2 Medical Exam	ysician: To the best of my kn	owledga, daath									
thin 24 hour thin 24 hour the Funer mpletely fil	one)	and manner statad.										
To To To To To To To To To To To To To T	29b. Signature and title of certifier	wave up			ES-000			(Month, Day, Year)				
9	30. Name and address of person who of Hetty Carraway	completed causa of death (Ita	m 23a) (Type,	Print)	tal Toner	10 Baltin	nore Man	gland Z120	5			
State	31. Data filed (Month, Day, Year)	32. Registrar's Sign					4					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death **Physician** Josephine Newell 2000 8:23PM /Medical October 4h. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Catonsville Baltimore 218 Stonewall Road Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□ M 21 F 082-16-6624 93 New York Yrs. Director July 28, 1907 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or flams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☐ No Directo Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 218 Stonewall Road Usa 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amaricen Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 □ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Cafeteria 8 Cafeteria Cook 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middla, Last) Montal should be Antonio Ruggiero Elisabetta Greco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) # Department of Health a important: if item 27 is any injury or other training 2005. Elizabeth Pasqurella-Daughter 218 Stonewall Road, Catonsville, Maryland 21228 20b. Place of Disposition (Neme of cematary, crametory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State cematary, crametory or other place) Baltimore/Washington Crem9,2000 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 22. Nama and Addrass of Facility Witzke Funeral Home 21. Signalul of Funeral Service Licen 1630 Edmondson Avenue, Catonsville, MAryland 21228 Approximate Interval Betwaan Onset and Death 23a. Part1_Enter the disease, or completified that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical O years heimel Examiner Due to (or es a consequence of) Physician/Medical Examiner i or Attending Physician: The law requires that the death certificate be executed after death. Director After this certificate has been signed by the attending physician and clin by the attending shysician and clin by the fundarial director, page 2 should be detached for use as the burish transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medicel examiner? Be 26. Piace of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home SPResidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury et Work? 28d. Describe how Injury occurred 27. Menner of Death 28b. Time of Division 5 Pending Investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide

Registrar

29a Certifier

29b. Signatura and titla of cartifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. 31. Date filed (Month (2) Year) 2 2000 32. Registraris Signature

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To the Hospital o within 24 hours at To the Funeral D

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29c. Licensa number

oaks

38762

Baltimore, Md.

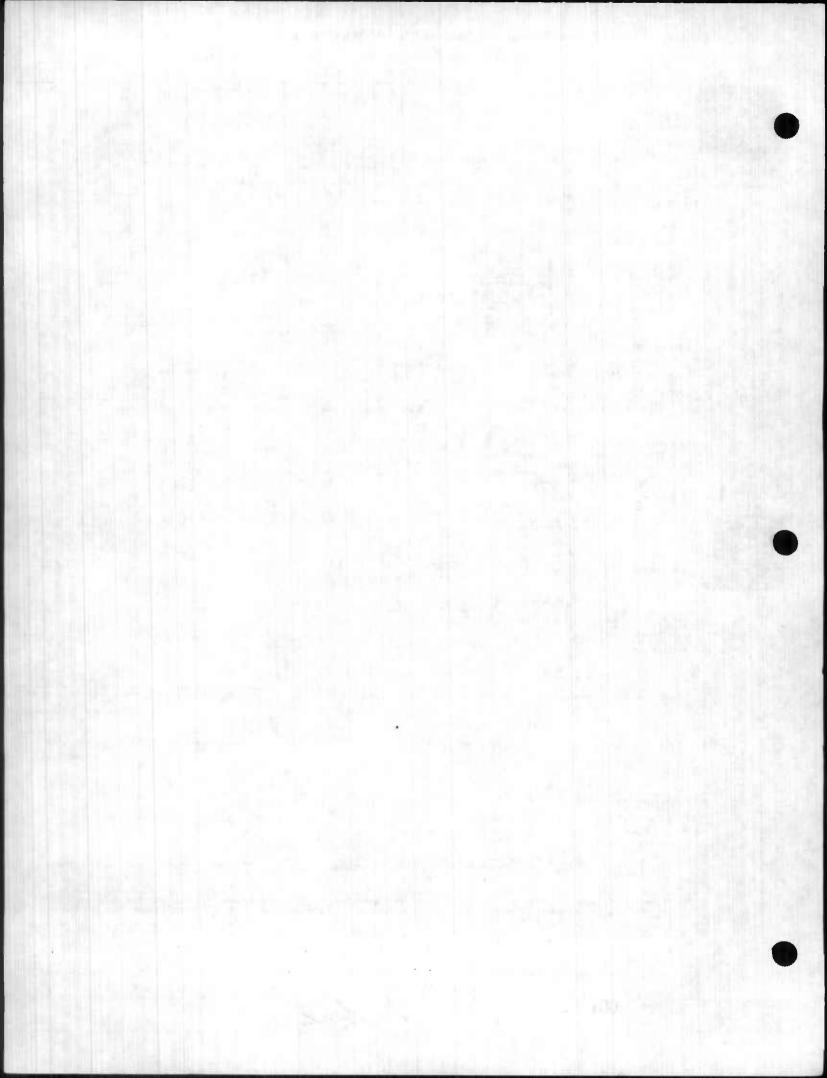
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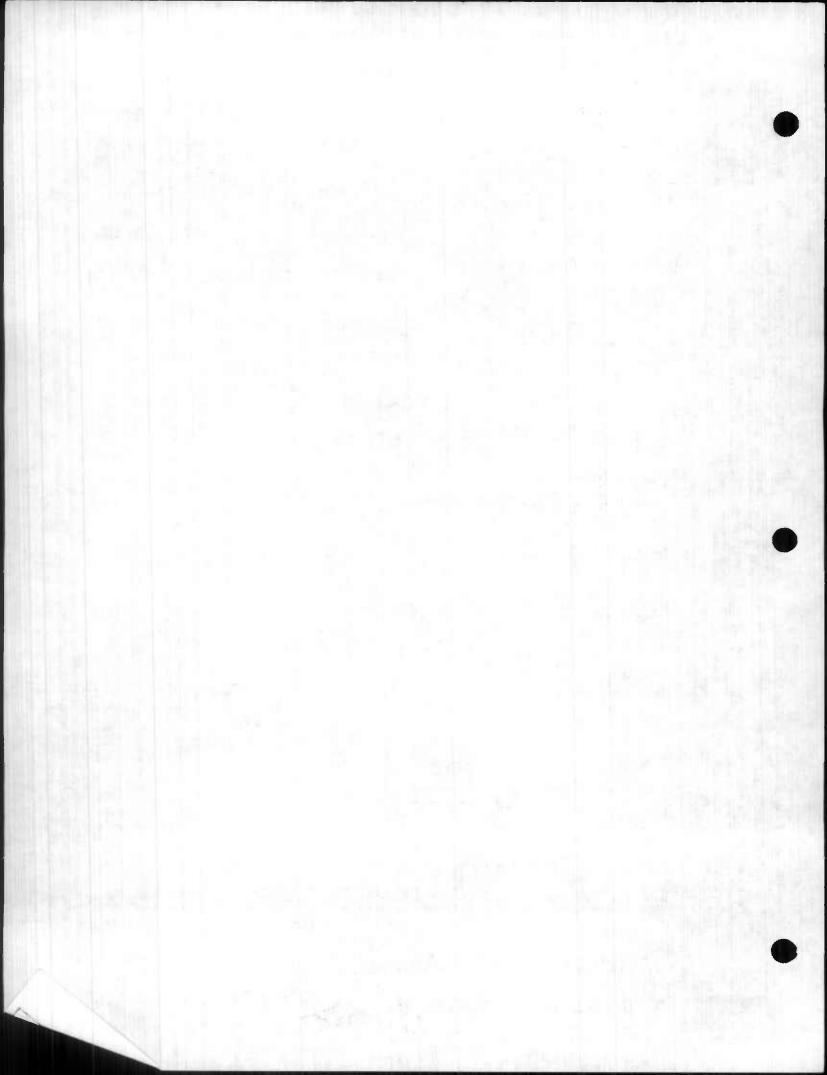
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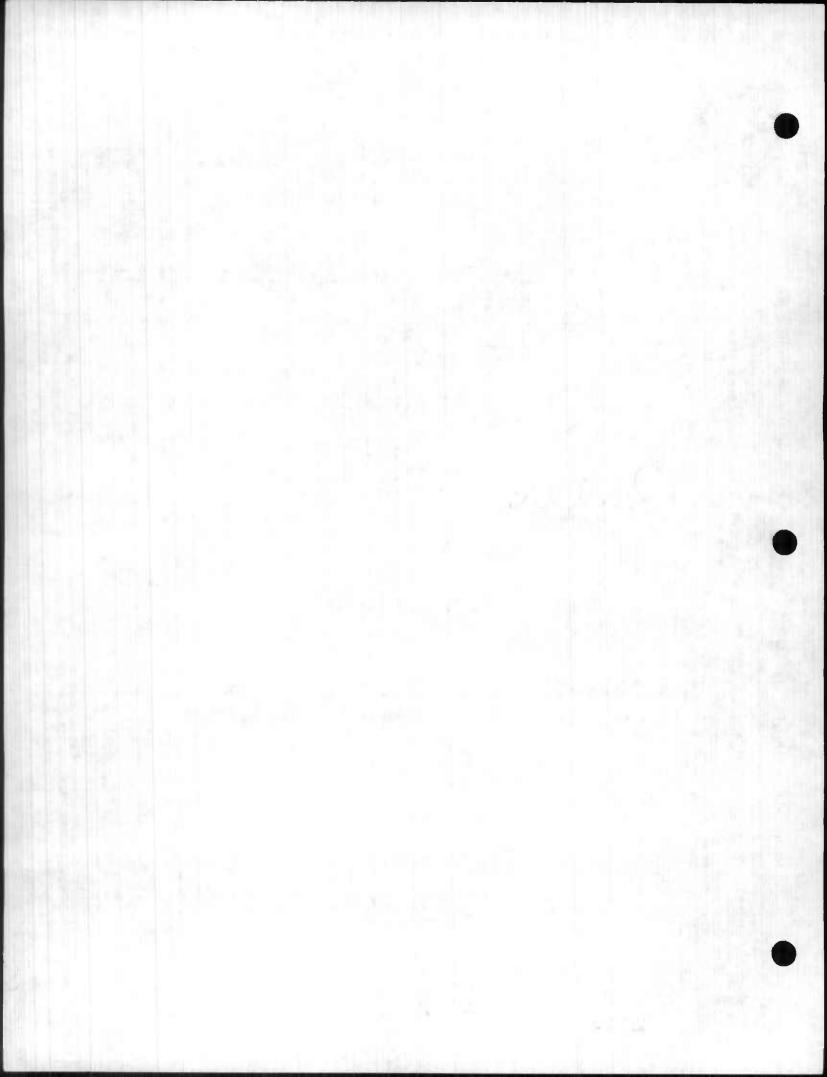
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					rtificate		Death		Reg. No.			
Physician	1. Decedent's Name (First, Middle, Last	1)						2. Date of D Month	Day	Year	3. Time of Death	
/Medical	Alexandra Obaturow							UCTOB		2000	MM	
Examiner	4e Facility Name (If not institution, give		nber)				4b. City, Town, or L Catonsvil		tri 4c. Coun	ty of Death	1.06	
	431 Chalfonte Driv 5. Social Security Number 6. Se		7. Age (In yrs.	last hirthday)	If Under	1	Jaconsvil If Under 24 Hrs.	8 Date of B	irth - 17	9 Birtho	lace (Stete or Foreign	
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	Usual Residence of Decedent							ALO A CIMBO	20,13	ртыс	VIU	
how	10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					1	0d. Inside City Limits	
vith the Marylan or 28a-f show be notified Director	MD Baltimor	e	Cat	onsvil	-			1 □ Yes 2				
Vith th	10e. Street and Number				10f. Zip (Code		13.0	10g. Citizen of What Country?			
death with the Maryland ms 23a or 28a-f show creat be notified at neral Director	431 Chalfonte Driv	e 12. Was Dece	dont Ever in II	16 13	2122		ienania Origin? (Si	pacifu Vae or N	USA 14 B	ace - Americ	en Indian	
5 22 5	11. Marital Status 1 Never Married 2 Merried	Armed For	ces?	1,5.	If Yes, speci	fy Cuba	lispanic Origin? (Sp an, Mexican, Puerto	o Ricen, etc.)	BI	eck, White,		
a 0 >	3 □Widowed 4 □ Divorced	If Yes, Give	е		1□ Yes 2	No	Specify:		Spec	'y Whit	e	
72 hours natural, see by	15. Decedent's Edu			16a. Dece	dent's Usual	Occup	ation	t in a	16b. Kind of	Busineas/Ind	dustry	
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T T T T T T T T T T T T T T T T T T T	17. Father's Name (First, Middle, Last)						18. Mother's Nan			eme)		
Mente arked	Philip Kulakov			401 44 77		(0)	Anna She		-	- Ct- t- 7:-	Code	
th and The m	19e. Informent'a Neme/Reletionship (T)						end Number or Ru					
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Parties P	4 Donation 5 Other (Specify)	tzke Funeral Home, Inc. nue, Catonsville, Maryland212										
To de la constante de la const	Multon	3	MANILA	12 1	630 E	lmor	ss of Facility Windson Ave	nue, Ca	itonsvil	le, M	aryland212	
all I	23a Farty Enter the dichase, or comp shock, or hear failure. List only o	lications that ca	aused the dea	th. Do not en	ter the mode	of dyir	ng, such as cardied	or respiratory	errest,		Approximate Interval Between	
/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	of the	Ro Sc. Due to (lo Ro T	quence of):	Rdi	' Ansey	AR S	SeASE		YEARS	
be axecuted ician and burial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury		Due to (or as a conse	quence of):							
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the ache	Politi. Other argument conditions co	Titributing to de	atti but not is	suring in the c	indenying ce	use giv	on in rail i.		Yes 2 No			
been should									s en eutopsy formed?	ev	ere autopsy findings alleble prior to impletion of cause death?	
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2 5 5	1 Yea 2 No	Hospitel: 1 🗆 Ir	npatient 2	ER/Outpatie	nt 3 DO	A Oth	ner: 4 Nursing H	lome 5 1	sidence 6 🗆 C	ther (Specia	(y)	
ding Ph. After th funeral	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date o (Monti	of Injury h, Dey Year)	28b. Time o	of 28	Bc. Injur Wor	y et rk?	28d. Describe	how injury occ	urred		
or Attendent frector: or by the	2 Accident investigation 3 Suicide 6 Could not be determined	28f. Location City or T	(Street end Nur own, Stete)	nber or Rure	el Route Number,							
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within 2 to the comple	29b. Sonature and title of certifier	Marin Di		~	29c.	Licens	se number		29d. Date sig	ned (Month,	Day, Year)	
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/	30. Name and address of person who co	ompleted ceuse	e of death (Le	m 23a) (Type,	Print)		11		0-7-5		Boul	
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State	31. Date filed (Many Per Year) 200	32. Re	gistrar's Sign	ature 4	-	-	- 12		212	18 m	ARHAM	



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		Certificate of L	Death	R	eg. No.									
		Decedent's Nama (First, Middla, Last)		2. Data of Deat	th	3. Time of Death								
	Physician /Medical	Edward P. O'Byrne Sr.		0ctöber	fo, 2000	9:45 AM								
	Examiner		b. City, Town, or Loc Catonsvil		4c. County of D									
,	Funeral Director	5. Social Security Number 6. Sax 1 Age (In yrs. last birthday) 1 Under 1 Year 212-03-9590 87 Yrs. 87 Age (In yrs. last birthday) 1 Under 1 Year Months Days	If Undar 24 Hrs. Hours Min.	B. Data of Birth (Month, Day, Mar. 1,	9. 1913 Ma	Birthplaca (Stata or Foraign Country) Tyland								
	g g m	Usual Rasidenca of Decedant 10a. State 10b. County 10c. City, Town or Location			7.75	10d. inside City Limite								
	and and and and and and and and and and	Maryland Baltimore Catonsville				1 ☐ Yas 2 ☐ No								
	th with the Maryla 23e or 28e-f show at be notified at al Director	719 Maiden Choice Lane, HR 341 21228			0g. Citizan of What USA	of What Country?								
Maryland 21215-0020	urs after das alf, or items Examiner m by Funer	11. Marital Status 1 □ Nevar Married 2 □ Married 1 □ Nevar Married 2 □ Married 3 ☒ Widowad 4 □ Divorced 12. Was Decedant Evar in U,S. Armed Forcas? 1 □ Yas 2 ☒ No 1 □ Yas 2 ☒ No 1 □ Yas 2 ☒ No		ify Yas or No- lican, atc.)	Black, V	marican Indian, /hita, etc. White								
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d 2	tal Hygin other event, if	17. Fathar's Nama (First, Middla, Last)	18. Mother's Name	(First, Middla, I	Maidan Sumama)									
/lar	Menta Menta riked file ev	Thomas O'Bryne	Blanche W	arren										
Aan	2 sho	19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Straat a												
	Health Nem 27 other tr	Patricia A. Vonasek / Daughter 2612 E. Northe 20a. Mathod of Disposition (Nama of	rn Parkwa		20c. Location - City									
Baltimore	Pages ment of tant: If the jury or o	1 □ Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Depation 5 □ Other (Specify)	10			e, Maryland								
Bal	and and and and and and and and and and	21. Signature d Funaral Sarvica Licansee 22. Nama and Addras Hubbard Fu 4107 Wilke	neral Hom	e, Inc. , Balti	more, Mar	ryland 21229								
		23a. Part 1. Enlar tha disaasa, or complications that causad tha daalh. Do not anlar tha mode of dying shock, or heart failure. List only one cause on each line.				Approximate interval Batwaen								
	Physician /Medical	1100 1000				Onset and Death								
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Ī	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, paga 2 medical Certification: To Be Comp	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time of the control of the death occurred at the time one)												
•	within Toth Comp	296. Signature and file of certifier D	26473		Data signed (A									
	10	30. Name and addrass of person who complated causa of death (Itam 23a) (Type, Print) Dornard F Costors lly TD 711	4 iven C	hoice	LANE, [ALTO 17 D 21228								
	State Registrar	31. Data filed (Month, Day, Year) OCT 1 2 2000 33. Registrar's Signatura Sports			·									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Physician OCTOBER 3 7:17 P.M. Joseph Orloskey 2000 Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner BALTIMORE FRANKLIN SQUARE HOSPITAL CENTER KOSEDALE If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Securify Number 7. Age (In yrs. last birthday) **Funeral** 15 M 20 F Months Days Hours Min. 212-20-3771 Yrs. 76 PA Director Uaual Residenca of Decedent r 28a-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Baltimore MD Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be o 21237 8024 Old Philadelphia Road USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 ★Yes 2 □ No
If Yes, Give
Yeer or Datea: WW I Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☑ Divorced 8 and 2 should be filed w...
and Mentel Hygiene.
—ricked other than "natural," W II White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Industrial Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Joseph Orloskey Anna Buhovesky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nem 27 Carol Weinreich/Niece 11736 Browntown Road Kennedyville MD 21645 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Important: If It, any injury or o 2009. 75 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 10-7-00 Baltimore MD Ture of Funeral Service Licens 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Baltimore MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical * KUPTURED HEART Examiner Due to (or es e consequenca of): Physician/Medical Examiner KIGHT VENTRICULAR LACERATION DURING PERICARDIAL WINDOW be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Last sicien and burial-trans Due to (or as a consequenca of) CTERICARDIAL AND EPICARDIAL ACHESIONS WITH LYSIS 68760 Due to (or as a consequenca of): the ADENOCARCINOMA Box METASTATIC use 23b. Did tobacco use contribute to the cause of death? PO Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. signed by 1 XYss 2 No 3 Probably 4 Unknown Records, p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 1 Yes 2□ No 1 Yes 2 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 → Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nuraing Home 5 Residence 6 Other (Specify) 1XYes 2□ No 10 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? Division or Attending 5 Pending investigation 1 Natural after death.

Director: Aft
d in by the fur 1 ☐ Yea 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end little of certifier RD # 187229 ML anor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

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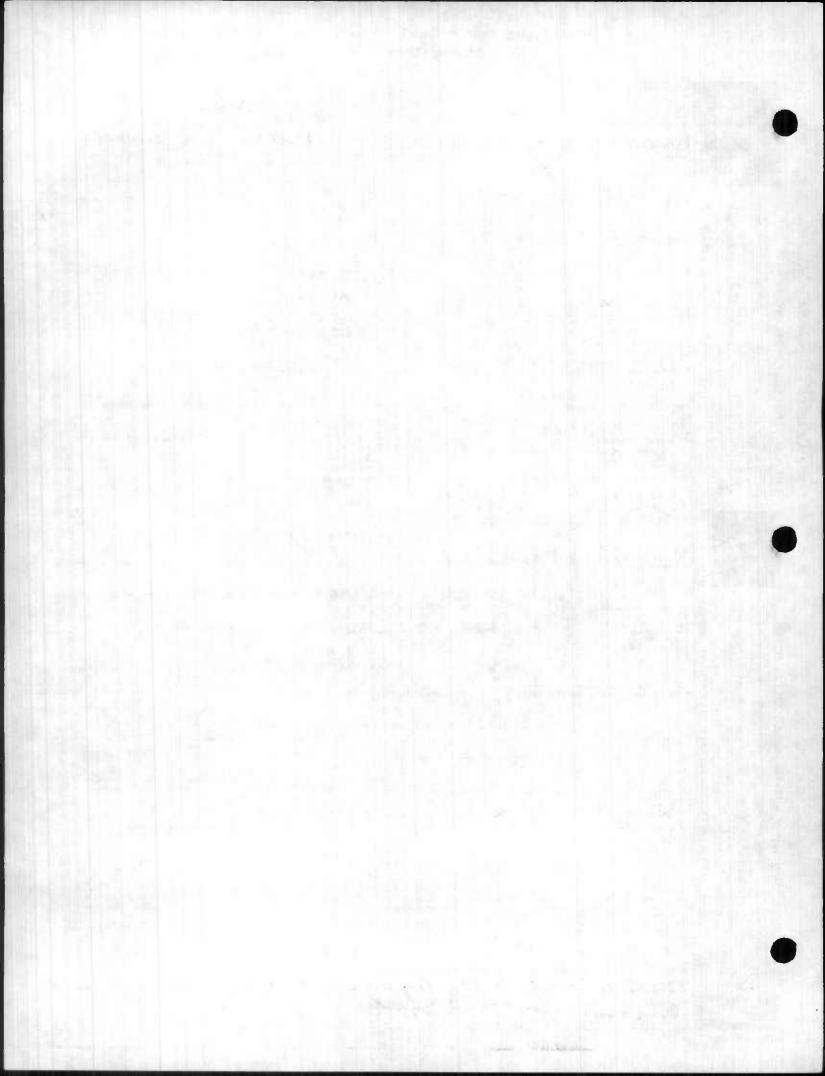
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State Registrar MCCARRON

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32 Registrar's Signature

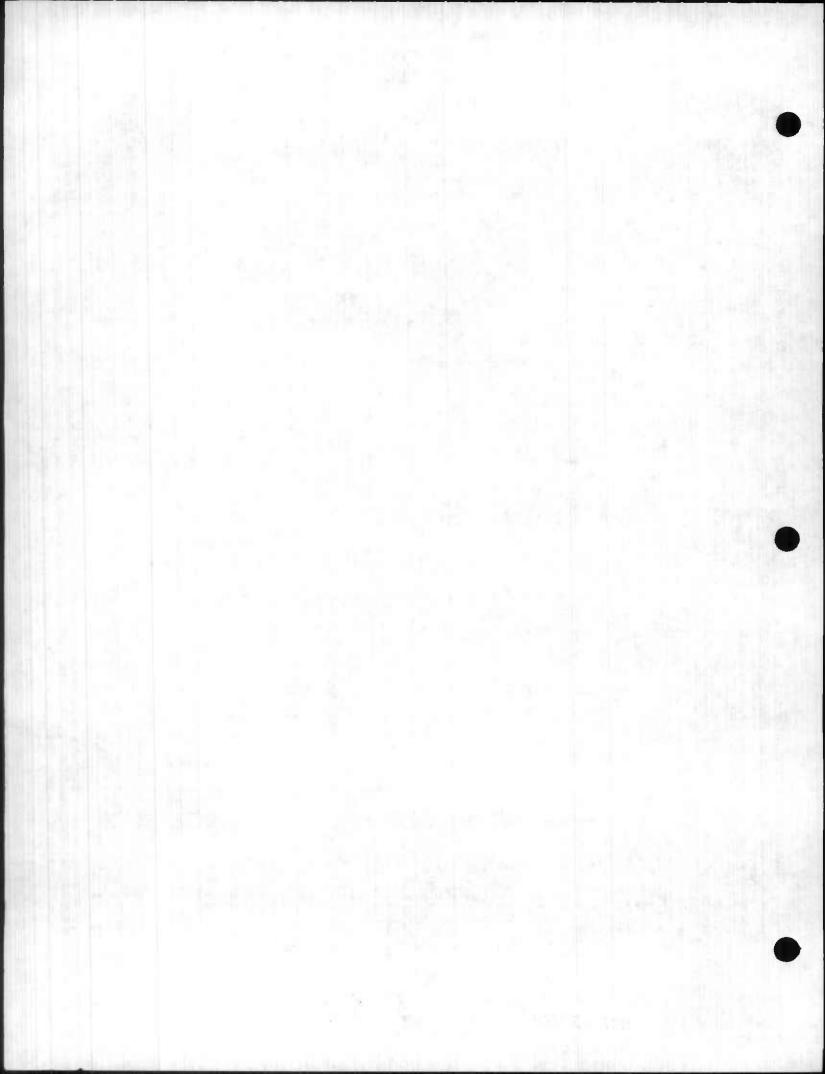
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State of Maryland / Department of Health and Mental Hygiene 0.0 2.2.1.5.0

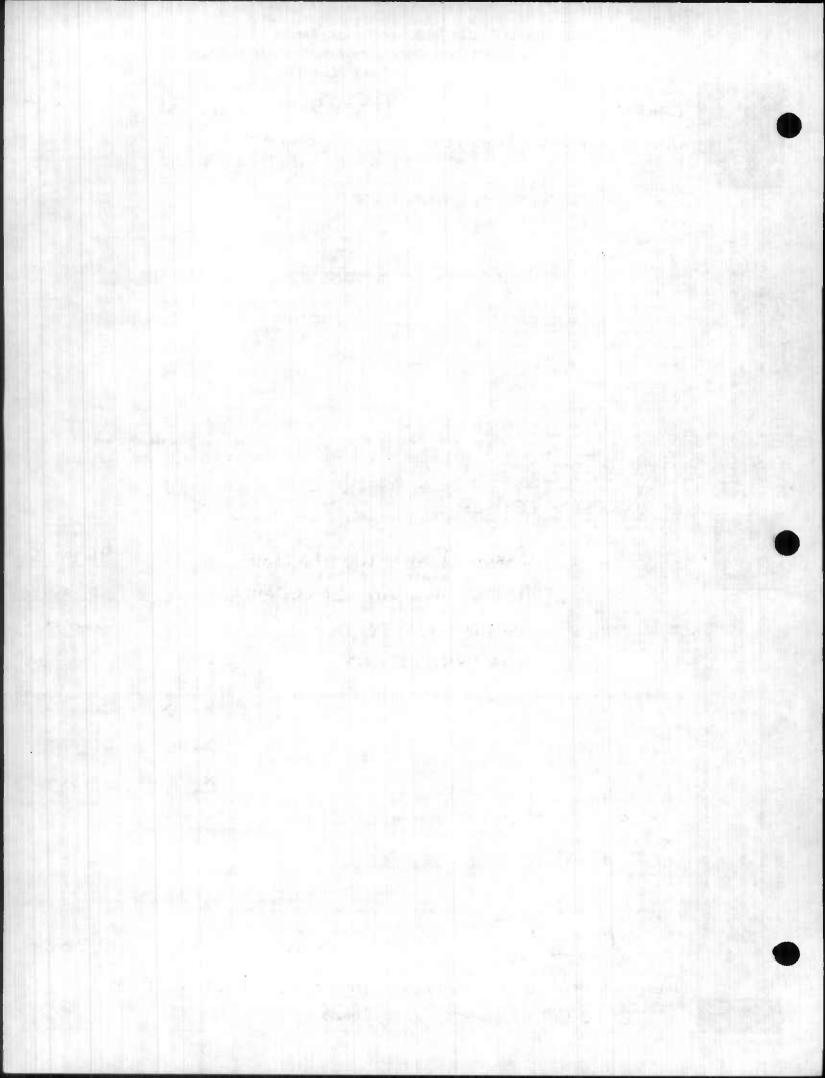
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Examiner	4a Facility Neme (If not institution, give st	ISON AUR. 10 7. Age (In yrs. lest birthdey)	107 Balti	2. Ocation of Death 4c. County of Ac. County	9. Birthplece (State or Foreign Gountry)
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death v	10e. Strefet and Number 1400 E. Mad 1 11. Mentel Stetus	SON AUQ (007 2. Was Decedent Ever in U,S. 13. Armed Forces?	10f. Zip Code 2/205 Was Decedent of Hispenic Origin? (Sill Yes, specify Cuben, Mexican, Puert	10g. Citizen of W	American Indian,
5-0020 72 hours after neturel; or te	1 Never Merried 2 Married 3 Widowed 4 Divorcad	1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:	1 ☐ Yes 2 ☐ No Specify:	Specify:	Black
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Midi yidiid Zik d 2 should be filed with th and Mentel Hygiene. Traumatic event, the traumatic event, the tra	17, Father's Neme (First, Middle, Last)	nkney	Mar	ne (First, Middle, Maiden Sumemer 10 n Joh	nson
i end 2 sho Heelth and tem 27 is m other traum	19e, Informent's Neme/Reletionship (Typ) 19e, Informent's Neme/Reletionship (Typ) 20e, Method of Disposition	+ Burke 26;	ng Address (Street and Number or Ru 23 N Hills position (Neme of	1 St. Balt	Stete, Zip Code) $ 0, Md, 2/2/6 $ City or Town, Stete
pariting fe, sentile. Pages 1 e Caparinent of Hee Important: If Item and Injury or othe once	1 ⊠ Buriel 2 ☐ Cremetion 3 ☐ Re 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses	mover from Stete M+, Z	metory or other plece)	10/16/2000 Lans	downe, Md
a se de de de de de de de de de de de de de	23a. Party Enter the disease, or compile shook, or heart fallure. List only on	L. Russ 3	oseph L. Rus	Aue Balto.	Md. 21216 Approximate Interval Between
Physician /Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth)	Due to (or es a conse	May do	eh	Onset and Death
axecuted and ial-transit	b.	Due to for es e conse	n84		
ificate be assected physicien and as the burial-transit edical Examir	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest	Due to (or es a consec	juenca of):	~e	
	d.	Penphral	Varmlen	discon	
es that the daeth certificated by the attending be detached for use a by Physician/M	Pert II. Other significant conditions control	ibuting to death but not resulting in the u	nderlying cause given in Pert I.	23b. Did tobacco use con	atributs to the causs of death? 3 Probably 4 Unknow
requir seen s should eted				24a. Wes en eutopsy performed?	24b. Were autopsy lindings eveileble prior to completion of cause of deeth?
stefan: The lew steerificate has birector, page 2 s				1□ Yes 2□No	1□Yes 2□No
To the Hospital or Attending Physician: The Iwithin 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	27. Menner of Deeth 1 IZNeturel 5 Pending	spital: 1 Inpatient 2 ER/Outpatie 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury	nt 3 DOA Other: 4 Nursing H	eth (Check only one) Iome 5 Presidence 6 □Othe 28d. Describe how injury occurre	
To the Hospital or Attanding P within 24 hours after death to the Funeral Director: After it completely filled in by the funeral Medical Certification:	2 Accident Investigetion 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Street and Number City or Town, State)	er or Rurel Route Number,
he Hospitu in 24 hours he Funera pietely fille	29e. Certifier 1 Certifying Physic (Check only one)	clan: To the best of my knowledge, deet ir: On the basis of examination and/or in and menner stated.	h occurred et the time, date end plece vestigetion, in my opinion, deeth occu	o, end due to the ceuse(s) and ma erred et the time, date end plece, e	nner es stated. and due to the ceuse(s)
To the compi	29b. Signature end title of certifier		29c. License number		(Month, Day, Year)
SR:	30. Neme end eddress ol person who con	pleted cause ol deeth (Item 23a) (Type	Print) Print) Fr Sm	10/12	
State	SHOAID A B	ASHMI 821 N. 32. Refistrar's Signeture	enton It Im	12 704, 150M	1. m1) 2/201
Registrar	207 4 9 200	1 Deneura	sporks		



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State of Maryland / Department of Health and Mental Hygiene 0 0 32 | 60

				06	rtificat	eoil	Dealli		R	leg. No.			
Physician	1, Decedent's Neme (First, Ma	ddle, Last)	S Moss		0		A		Month Dey Yeer				
/Medical	LOREN				MET		SHE		DCTOBER	8 :		9. 30 n	
Examiner									o RE	Wonth TOBER 8 ZCCC 9 30 A 4c. Country of Death N/A Pate of Birth Month, Dey, Year) Photober 14, 1945 10d. Inside City Limits 1 Yes MXNo 10g. Citizen of Whet Country? United States Yes or No- n, etc.) 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Kitchen Cabinetry st, Middle, Meiden Sumeme) Stiller ute Number, City or Town, State, Zip Code) PA 17562 ete 20c. Location - City or Town, State er 11, 2000 Paradise Twp., PA Home, Inc. timore Maryland 21230			
Funeral Director	5. Social Security Number 205–36–8650	6. Sex 1 <u>M</u> M 2□		rs. last birthdey, Yrs.	Months Months	Deys	If Under: Hours	Min.	8. Date of Birth (Month, Dey October	Year) 14, 1945			
	Usual Residence of Decedent 10a. State 10b. Cou	nhy	100	City, Town or Lo	ocation						11	Od Ineido City I Imit	
28a-f show notified at rector		ncaster	100.		brdonv	ille,	PA						
13e or 2u at being	10e. Street end Number 3753 Ridge Road				10f. Zij	Code 1756	2			I0g. Citizen of W			
al, or items 23e or 28e-1 e Laminet must be notified by Funeral Director	11. Marital Status 1 Never Merried ** 3 Widowed 4 Divor	Arme	Decedent Ever in de Forces? Yes 2 XXIII o s, Give or Detes:		Was Dece If Yes, spe 1 Yes	cify Cuba	lispanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	Black	c, White, o	etc.	
nt free Medical	(Specify only hig	dent's Education thest grade comple		(Give	ident's Usu is kind of wo DO NOT u	ork done o	during most	t of worki	ng	16b. Kind of Bu	siness/Ind	lustry	
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merked other imeric event, To Be C	17. Father's Name (First, Midd Oliver Peter						18. Mothe		(First, Middle, 1 Diller	Meiden Sumem	9)		
trau trau	19e. Informent's Neme/Relati Anna S. Ranck)								Stete, Zip	Code)	
of Tear	20e. Method of Disposition **XX Buriel 2		Inner Ctota	Plece of Disponents, cre Paradise	metory or	other pled		y ¢c	Dete tober 11,				
Department Important: I any injury o poce.	21. Signature of Funeral Serv		P. Dod		harles	L. S	ss of Fecilit tevens	Fune	ral Home,	Inc.	2123	80	
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sician	SHOOK, OF HOOK FAMILIES.						J				1	Onset and Death	
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icien end bunal-transit ai Examiner	Sequentially list conditions, if env, leading to immediate cause. Enter Undertying									SWREE			
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2 should									24a. Wes o	en eutopsy med?	CO	ere autopsy finding eiteble prior to mpletion of ceuse death?	
ate hes page 2									JAY.	es 2□No	1 [Yes 2 No	
certificate rector, pay	25. Was case referred to med examiner?						26. Place	of Deetl	n (Check only o	ne)			
8 D	1 ☐ Yes 2 No 27. Menner of Deeth	Hospitel:	Dete of Injury Month, Dey Year	28b. Time of		OA Oth	4 1110	,		ence 6 Other		γ)	
	1 Molecural 5 Per	-OIL-M			М		Yes 2			Street and Number	er or Rure	l Route Number	
	3 ☐ Suicide 6 ☐ Cou	estigetion ald not be emmined 28e. F	Plece of Injury - A	t home, ferm, st	treet, factor		4 Hornicide building, etc. (Specify)						
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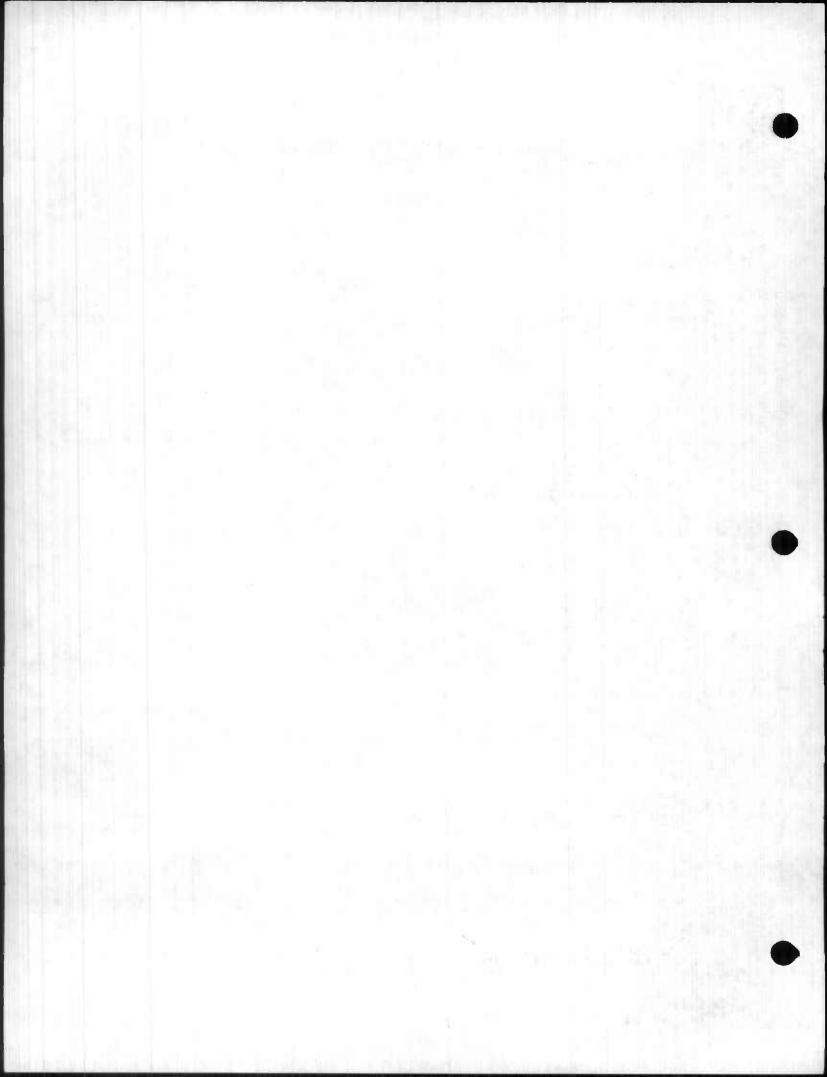
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Certificate of Death

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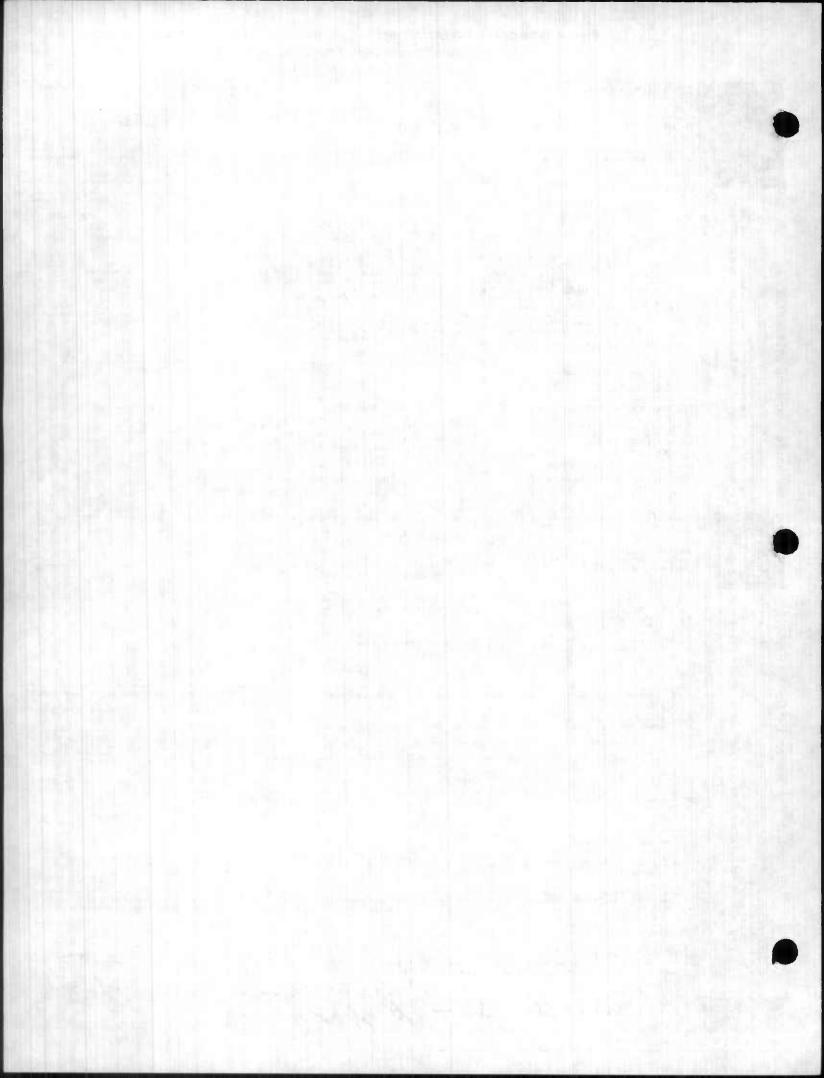
					Certifica	ate of	Death	1	Reg. No.	32161
ysician	1.	Decedent's Name (First, Middle, La	PRAKAS	(11				2. Date of Dec	ath Day	3. Time of Deat
Medical aminer	4a	Facility Nama (II not institution, give		1 16	spital		6 UMA	r Location of Death	4c. County of	of Death
eral ctor	2		Sex 7. Age 1	(In yrs. last b	Yrs. If Und Month	der 1 Year ns Days	If Under 24 Hr Hours Mir			Birthplace (State or For- Country) India
N N	10	Da. State 10b. County	TRAVE OF		wn or Location					10d. fnside City Lin 1 ☐ Yes 2
must be notified eral Director	10	laryland Howard		上上	licott	Zip Code			10g. Citizen of W	hat Country?
vaminer must by Funeral		3300 Hibiscus Co Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forcas? 1 ☐ Yas 2 ☒ No If Yes, Giva Year or Dates:			cedant of I- pecify Cub	043 dispanic Origin? (an, Mexicen, Pue Specify:	Specify Yes or Norto Rican, etc.)	Black	- American Indian, K, White, etc. Asian Indian
		15. Decedent's E (Specify only highest gr.	ducetion		a. Decedent's U (Give kind of	suat Occup work done	pation during most of w	orking	16b. Kind of Bu	
Completed		Elementery/Secondery (0-12)				Tuse retire	d)		Educat	ion
o Be	17	7. Father's Nama (First, Middle, Last					ame (First, Middle,		9)	
1	-	Manammed Syeed 99. Informent's Neme/Reletionship		19	b. Maiting Addre	ess (Street		ikhiya Be Rurel Route Numbe		Stefe, Zip Code)
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ance	A Donation 5 Other (Specify) Metro Crematory Inc. 10-10-00								Baltimore, MD Inc. imore, MD 21228	
as the burial-transit uear Medical Examiner	di re	nmediate Cause (Final isease or condition sulting in deeth) equentially list conditions, eny, leeding to immediate suse. Enter Underlying ause (Disease or Injury lat initiated events sulting in death) Last	b	ue to (or as a	Breast a consequence of a consequence of	of): of):	rcino	na		3415
ian/		art II. Other significant conditions of	d	not resulting	in the underlyin	g ceuse gi	ven in Part I.	23b. Did	tobacco use con	atribute to the cause of de
by	-								Yes 2 No	
piete								24a. Was perfo	an autopsy ormed?	24b. Were autopsy findir availabla prior to completion of cause of death?
0	25	5. Was case referred to medical					26 Place of O	1 □ 1		1 Yas 2 No
ř		examiner?	Hospital:	-	Outpetient 3	DUA	her: 4 🗆 Nursing	Home 5 Resid	dence 6 Othe	
Certification:	27	7. Manner of Death 1. Netural 5 □ Pending 2. □ Accident investigation 3. □ Suicide 6 □ Could not be		Year)	Time of Injury M	1 🗆	ryat rk? ∣Yes 2 □ No		how injury occurr	er or Rural Route Number,
6 =		4 D Homicide	determined 200, Flace of thiury - At home, latin, Street, lactory, office						wn, Stete)	
Ce Le		Pa. Certifier 12 Certifying Pt	hysician: To the best of	xamination a	ge, death occurr and/or invastigat	ed at the ti	me, date and pla opinion, death oc	ce, and due to the curred at the time,	date and plece, e	nner as stated. end due to the cause(s)
edical Cert		(Check only 2 Medical Examone)	and manner state	øu.						
Medical	29	(Check only 2 Medical Example 1997)		9 0.	110	29c. Licans	sa number			(Month, Day, Year)
pletely fit edical	29	(Check only 2 Medical Example)	and manner state	an	MP	29c. Licans	3323	li-Kapn		(Month, Day, Year)



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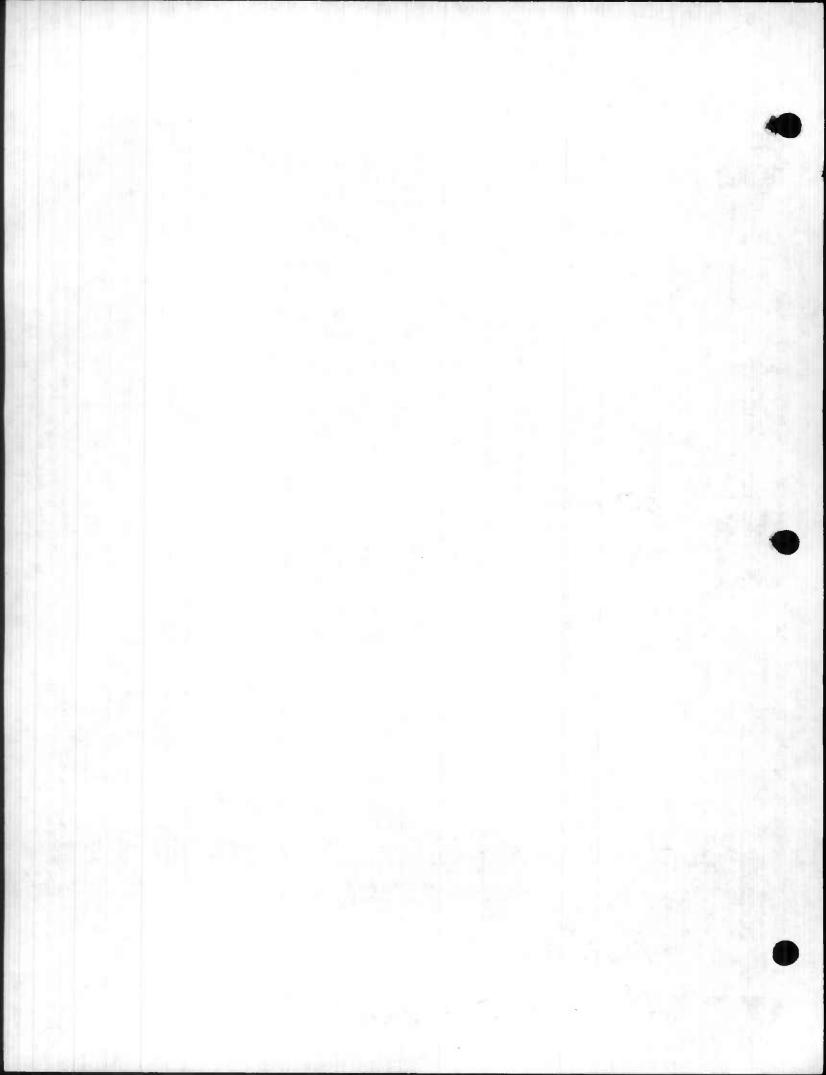
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							Certi	ficate of	Death	Re	g. No.	3 32102		
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2770	Physician	_	UNRO	this				Huv	MMFR	MORE	2 09	7000 10100	Dan	
	/Medica Examine	-	ta Facility Name (I	f not institution, give	e street, and number)	4.		- 1	4b. City, Town, or Lo	cation of Death	4c. County	of Death	-	
di c	Examine	. 1	Johns	HOPKIN.	BAULTE	J/12	Drent	Coster	Bolt	und6				
-	Funeral	w i	5. Social Security N			e (In you last	birthday)	Under 1 Year	If Under 24 Hrs.	8. Date of Birth Month, Cay, Dec. T,	Vessel	9. Birthplace (State or Fo	oreign	
	Director		218-14-	2972	IDM 200F	78	Yrs.	forths Days	Hours Min.	Dec.1,	1921	Birthplace (State or Fo Country) Md		
-	70		Usual Residence of	Decedent										
	rylar thom		10a. State	10b. County		10c. City, To	own or Locat	ion				10d. Inside City Li		
	h the Maryla r 28a-f show a notified at	Directo	Md.	N/A		Bal	timor	e City				1 Yes 2	□No	
	Mith th	8	10e. Street and Nur	mber				10f. Zip Code		10	Og. Citizen of V	Vhat Country?		
			6425 Da	nville	Ave.			21224			USA			
	dear dear	ner	11. Meritel Stetus		12. Was Decedent Armed Forces?	Ever in U,S.	13. Was	Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		e - American Indian, ck, White, etc.		
21215-0020	English T	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced		1 ☐ Yes 2 M If Yes, Give Year or Dates:	No 1 ☐ Yes 2 No Specify:		, , , , , , ,	Specify					
5-0	72 h	Completed	(Sne/	15. Decedent's E	ducation	10	6a. Deceden	t's Usual Occup	eation during most of work	ina	16b. Kind of Bu	usiness/Industry		
2	1	d	Elementary/Seco		College (1-4or	5+)	(Give kind of work done during most of working life. DO NOT use retired)							
	A STATE OF THE PARTY OF THE PAR	0	7 Yr				Housewife				Own Home			
Maryland	STATE OF THE PARTY		17. Fether's Name						18. Mother's Name			10)		
yla y	Manual Ma	0	Alexan	der Nod	only				Elizabe	th Fack	ett			
ar	and and and and and and and and and and		19a. Informant's Na								al Route Number, City or Town, State, Zip Code)			
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altimore	pages 1 ent of He at: If Hen ry or oth	-			Removal from State	ceme		on (Name of ory or other plea Cemete		ct 13,		City or Town, State		
芸	Info	-	21. Signature of Fu			20	22. N	ame and Addre	ss of Facility					
ä	FARES		D/ 1.+	hours	Conne	00.	Con	nelly	Funeral	Home o	f Dune	dalk, P.A.		
	_	+	23a Part Fnter ti	he disease of com	polications that caused	the death. I	711	0 Soll	ers Poir	nt Rd.	Dunda	lk, Md. 21	222	
4	Dhusisian		shock, or hee	rt failure. List only	plications that caused one cause on each li	ne. U						Interval Betwee Onset and Deat	en ith	
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/	nsit	Examiner			b	19 CA	NCKK					GINORA	45	
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Вох	for for							23b. Did tobacco use contribute to the cause of		44-0				
0	ed by the detached	138	Part II. Other signif	icant conditions	contributing to death b	ut not resultin	g in the unde	rrying cause giv	en in Part I.					
Δ.	ed by detac	7	CORONARY ARTERY VESKASK						1 LI A	1 Yes 2 No 3 Probably Mulinknow				
Vitai Records,	w requires that been signed b should be determined by the bear and the	a Dy								24a. Was a	n autopsv	24b. Were autopsy findi	ings	
Ö	need shou	ele								perform	ned?	evailable prior to completion of caus	50	
360	9 O N	E I										of death?		
- E	The le	3				31-6				1 🗆 Ye	s 2 2 No	1 ☐ Yes PZNo		
1	Physician: The this certificate ral director, per		25. Wes case refer examiner?	red to medical	Manager			100	26. Place of Deat	h (Check only on	ө)			
of	5 00	2	1□Yes 2		Hospital:		/Outpatient	3 DOA Oth	4 U Nursing Ho	me 5 Reside				
	leath. lor: After th the funeral		 Manner of Deat Matural 	h 5 ☐ Pending	28a. Date of Inju (Month, Da	ly Year) 28	b. Time of Injury	28c. Injui		28d. Describe ho	w injury occur	red		
Sio	Attending or death.	B	2 ☐ Accident	investigatio				M 1 🗆	Yes 2 No					
Division	its or Attending Price after death. El Director: After to the funeration by the funeration.		3 ☐ Suicide 4 ☐ Homicide	determined	286. Place of inj	ury - At home c. (Specify)	, farm, street	, factory, office		28f. Location (St City or Town	reet and Numb , State)	per or Rural Route Number,	τ.	
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	2												
	ne Hospital ne Euneral plately filled	2	29a. Certifier (Check only			f examination						anner as stated. and due to the cause(s)		
	within 24 To the Fi complate		one)		and manner st		- 1							
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	0		30 Name and Addr	ess of person whe	completed cause of c	teath (Item 23	a) (Type/Psi	nt) (2	L	A	711	M 121	1224	
_			TARK	100	SWNELL	MD	79	40K	STRANT	JVKUUK	DAUGA	TOLK, HARY HAD)	
	State		31. Date filed (Mon.	OCT TO	2000 32. Regist	er's Signature	4	do-	1,			, ,		
	Registrar	r					/~	papar	RS					



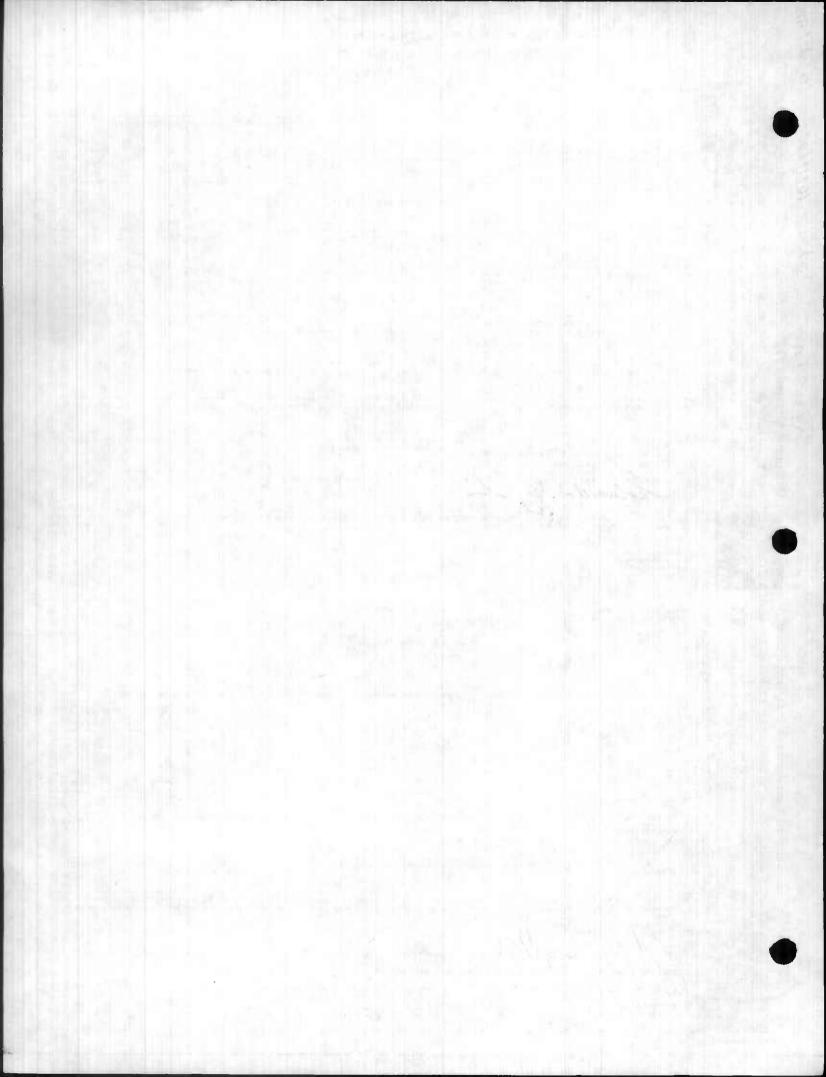
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				Cel	uncat	e or	Death			Reg. No.			
	1. Decedent's Nama (First, Middla,	Last)	11211791			- 1		1	2. Data of Dea	ath Day	Yaar	3. Tim	a of Death
ician dical	GERALD CLIFTO	ON ROBIN	ETTE, 5	JR.					CTOBE		2000	12:	25 PM
	4a Facility Name (If not institution,						4b. City, To		ation of Daath		ounty of Death		
1101	CLEMENTS STREE	ET					BUS	HWOOD)	ST	. MARY	19	
1		6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under						te or Foreign
	230-35-5611	XIX M 2 F	27	Yrs.	Months	Days	Hours	Min.	3. Date of Birt (Month, Da 10/16/	72	VIR	GINIA	A
t	Usual Residence of Decedent												
	10a. State 10b. County		10c. City	y, Town or Lo	cation								e City Limits
I	VA CHARI	LOTTE		RAKES	BRAN	CH						101	es 2 No
	10e. Street and Number	100000			10f. Zip	Coda	1.0			10g. Citizer	of What Cou	ntry?	
ı	201 C C C ROAD					2393	7			USA			
	11. Marital Status	12. Was Dece	dent Ever in U,	S. 13.				gin? (Spec	ify Yes or No ican, etc.)		Race - Ameri		١,
	1 Nevar Married 2 Married	Armed Fo	2 X No					i, Puerto H	ican, etc.)		Black, White,	etc.	
	3 Widowed 4 Divorced	If Yes, Giv Yeer or D	etes:		1 ☐ Yes	2 KN NO	Specify:			Sp	pecify: Wi	HITE	
	15. Decedent's	Education		16a. Deced	dent's Usu	al Occup	ation			16b. Kind	of Business/In	ndustry	
	(Specify only highest (Secondary (0-12)	College (1	-40r 5+\	lifa.	DO NOT u	se retire	during mos d)	or working	9				
	10TH GRADE	College (401 34)	OF	PERAT	OR				CONS	TRUCTIO	ON CC).
ĺ	17. Father's Name (First, Middle, La	est)	Silly				18. Mothe	r's Name ((First, Middle,				
	GERALD CLIFTON	ROBINETT	E, SR.				SHI	RLEY	SEAMST	ER			
ĺ	19a. Informant's Name/Relationship	p (Type, Print)		19b. Mailir	ng Address	s (Street					own, Stete, Zi	p Code)	
1	CHRISTY W. ROBIN		WIFE	201 0	CC	ROA	ם ח	AKES	BRANCH	. VA	23937		
1	20a. Method of Disposition		20b. P	lace of Dispo	sition (Na	me of		THE STATE OF THE S	Date	_	tion - City or T	own, State	9
	1X Burial 2 Cremation 3		State	emetery, crar						-	D. 11100		
-	4 Donation 5 Other (Spe 21. Signature of Funeral Service Lice		TRI	NITY C			. CEM		/12/20	100 D	RAKES I	BRANC	H, VA
l	21. Signature of Furieral Service Lit	A A							HOME,	P.A.			
	M. Ment	dener		8	3521	LOCH	RAVE	N BLV	D. TO	WSON,	MD 2	1286	
	23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that c	ausad tha daath	n. Do not ant	er tha mod	da of dyir	ng, such as	cerdiac or	raspiratory a	rrest,		Approxi	mate Between
			/	2		<						Onset a	nd Death
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ı	rasulting in deeth)	а	Due to (o	r as a consec	quence of):	:		77.00					
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	Sequentially list conditions,	0.	Due to (o	r as a consec	quence of):	:							
l	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events												
l	that initiated events resulting in death) Last	C	Due to (or	r as a conseq	uence of):								
medical Examiner													
		d				-							
t	Part il. Other eignificant conditions	s contributing to de	eath but not resi	ulting in the u	nderlying o	ceuse giv	ven in Part I		23b. Did	tobacco us	e contribute	to the cau	ee of death?
				Mary .					10	Yee 2	No 3 Pro	obably	Unknow
									24a. Was	an autopsy	24b. W	Vere eutoj vailable p	sy findings
									pend	rmed?	C	ompletion death?	of ceuse
									. ald	Yes 201		1	2□ No
-	Of 144										NO I	Tos	2U NO
	25. Was cese referred to medicel examiner?	Hospital:				Ot Oth	her.		(Check only o				
	1 ∑Yes 2 ☐ No 27. Manner of Death	1 1 1		ER/Outpatier 28b. Time of		UA	4LIN	rsing Hom	e 5 Resi		Other (Spec	ity) SC	ene .
			of Injury	Injury		28c. Inju			in olem	nife	or to	mer	line on
-	1 Naturel 5 Pending	-///	100	10301	-	٩٠٠	Yes 2□	4	lasen,	wine		LO I	ryc
L	1 Naturel 5 Pending Investigat	N DB	of Injury - At ho ng, etc. (Specif)	ome, farm, str	reet, factor	y, office		20	City or To	wn, Stete)	Number or Rui	ra/ moute	vumber,
	1 Naturel 5 Pending	ad 200 Place		Chep	4 ml	ten					Clemen	5 M	my land
	1 □ Naturel 5 □ Pending 2 ♣ Accident Investigat 3 □ Suicide 6 □ Could no	ad 200 Place			-				1 1 1 15			ctated	
	1 Naturel 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Ex	Physician: To the											se(s)
	1 Naturel 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying	Physician: To the traminer: On the ba								date and pl	ace, and due	to the cau	
	1 Naturel 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Ex	Physician: To the traminer: On the ba	isis of examinat		vestigation	n, in my o				date and pl		to the cau	
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Medical Certification	1 Naturel 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and titla of certifiar	Physician: To the traminer: On the band man	asis of examination stated.	tion and/or in	vestigation 29 Print)	c. Licans	sa number C.M.	E.	d at the tima,	29d. Date s	lace, and due	Day, Yeu	00



Division of Vital Records, P.O. Box 68760,

	Please 1	ype or Print In B State of Maryland	d / Department			ene	32164
	Decedent's Name (First, Middle, Last)		Continoute		2. Date of Death		3. Tima of Death
Physician	1	ohn Anthony	Pausing		Month	11. 200	00 10:23 AM
/Medical Examiner	4a Facility Name (If not institution, giva		Kedsing	4b. City, Town, or	Location of Death	4c. County of C	
2	Gilchrist Cen	ter		Towson	n	Balt	timore
Funeral	5. Social Security Number 6. Sec	7. Aga (In yrs. II	Months	1 Year If Under 24 Hrs Days Hours Min		eer) 9.	Birthplace (State or Foreign Country)
Director	168-26-1895 Usual Residence of Decedent	67	Yrs.		SEPT 18,	4000 -	Pennsylvania
deeth with the Meryland ms 23a or 28s-f show count be noticed at neral Director	10a. State 10b. County		, Town or Location	11 . 1	15.51		10d. Inside City Limits 1 ☐ Yas 2 ☐ No
vith the Me or 28s-1 s be notified	Maryland Howar	d	10f, Zip	1kridge	100	. Citizen of Wha	it Country?
23a or unit be	5968 Autumn	Snell		21075		T	JSA
fter deeth 'r hems 23		12. Was Decedent Ever in U.S		ent of Hispanic Origin? (Sify Cuban, Mexican, Pua	Specify Yes or No-	14. Race -	Amarican Indian,
or he	1 Never Married 2 Married	Armed Forcas? 1 ∑ Yas 2 □ No If Yes, Give	1 ☐ Yas 2	V	no Alcan, etc.)	Specify:	White, etc.
E C	3 ☐ Widowed 4 🖺 Divorced	Yaar or Dates:	12 740				White
rat of	15. Decedent's Edu (Specify only highest grade		16a. Decedent's Usua (Give kind of wor life. DO NOT us	k done during most of wo	orking 16	b. Kind of Busin	ess/industry
ygiene.	Elementery/Secondery (0-12)	College (1-4or 5+) 5 +				Treatn	9
Hygin Hygin	17. Father's Name (First, Middle, Last))+	Counse		me (First, Middle, Me	iden Sumeme)	
ked out ic avar	John Nicholas	Reusing		Sara	O'Brien		
and N	19a. informant's Neme/Relationship (Ty	pe, Print)	19b. Mailing Address	(Straet end Number or F	tural Route Number, C	City or Town, Sta	nte, Zip Code)
permit. Pages 1 and 2 should be filed within Department of Health and Montal Hygiene. Important: If Itam 27 is marked other than any injury or other traumatic avant, the Holes. To Be Compl	Grace E. Reusi	ng/Daughter	5968 Au	tumn Speli	l Elkric	lge, MI	21075
of He	20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ R	C6	lace of Disposition (Nemerotery, cremetory or of	a of her pleca)	Date 20	c. Location - Cit	y or Town, State
amt: h	4 Donation 5 Other (Specify)	Met	ro Cremat		10/12/00		
mport mport any inj	21. Signature of Puneral Service Licental	7.	22. Name and Crema	Address of Facility tion Socie	etv of MI). Inc.	
80588	Edward A. G	regorchik	299 F	rederick 1	Road Bal	ltimore	e, MD 21228
	23a. Part1. Enter tha diseasa, or complete shock, or heart failure. List only or	cations that caused the death ne cause on each line.	. Do not enter the mode	of dying, such as cardia	ac or raspiratory arras		Approximate Interval Between Onset and Death
Physician /Medical Examiner	Immediate Cause (Final disease or condition	newoa	ndocrine	tumor o	fpmer	TRAS	1 year
	resulting in deeth)		as a consequenca of):				
and I-transit	Sequentially list conditions,	Dua to (or	as a consaquenca of):				1
9 E E M	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
physician is the buria	that initiated events resulting in death) Last	Due to (or	as a consequence of):		1000		
at the death certification of the attending stacked for use a Physician/Me							1
0 5 9	Pert II. Other significant conditions con	tributing to death but not resu	ulting in the underlying ca	use given in Part I.			bute to the cause of death?
5 60					1 Yes	2 NO 3	☐ Probably 4 ☐ Unknow
The lew requires that sate has been signed to page 2 should be det.					24a. Was an		24b. Were autopsy findings available prior to completion of causa
hes b					The state of	_	of death?
icate he					1 ☐ Yes	285 No	1 Yas 2 No
this certificate ral director, pag	25. Was case referred to medical axaminar?	lospital:		Other:	eath (Check only one)	- a lon.	must be a si
this raid in	1 ☐ Yes 25(No	1 Inpatient 2 I	ER/Outpatient 3□ DO 28b. Time of 2	A 4 Nursing Bc. Injury et Work?	Home 5 Residen		
Attanding Profession of the funer by the funer iffication;	1 Netural 5 ☐ Pending investigation	28a. Date of Injury (Month, Dey Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
tal or Attanding P rs after death. at Director: After b led in by the funers Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, ferm, street, factory	, offica	28f. Location (Stre City or Town,		or Rural Route Number,
To the Hospital or Attanding within 24 hours after death of the Funeral Director. After completely filled in by the fune Medical Certification	29a. Certifier 123. Certifying Phys	sician: To the best of my know		at the time, dete and plea	e, and due to the ceu	se(s) and menn	er as stated.
To the Hospital within 24 hours To the Funeral completely filled		ner: On the basis of examinate and manner steted.					
Within To the comp	29b. Signature and title of certifier	10		Licensa number			Month, Dey, Year)
5	Hothow	Vales,	no D	25205	0	otober	11,2000
W.7	30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Print)	20	(1)	0.	11,2000 ud 21204
A.	W. A. Rely	GBINC 6	701 N.	Charles	It. Fa	cts. v	20212 pm
State	31. Date tiled (Month, Day Ymr)	32. Registrar's Signat					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 26,29d per HOSP, PHY, 788, 10/12/00dhb Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Daeth **Physician** 4:45a.M nomas ember /Medical 4b. City, Jown, or Location of Deeth 4a Fecility Name (If not institution, give street and/huj **Examiner** BALTIMONE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth **Funeral** 10 M 20 F 70 Yrs. Months Deys Hours Known as Thomas Keynolds -26-22 (arolina Director Usuei Residence of Decedant 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Woodlaw 1 ☐Yes 2 ☐ No Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 12. WesiDecedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. ed other than "natural", or itser event, the Medical Examiner Black, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: ģ 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NO) use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) Coitaga (1-4or 5+) Dishwasher was 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) 89 Mental Imoth 19a. Informent's Name/Reletingship (Type, Frint) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Wala rota 20b. Place of Disposition (Nema of cemetery, crematory or other) 20e. Method of Disposition 20c. Location - City or Town, Sta 1 Buriel 2 □ Cremation 3 □ Removal from Stete Lang. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Spryice Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximete Intervai Between **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if eny, laading to immediate causa. Enter Underlying Ceuse (Disaase or injury that initiated events resulting in death) Lest DivIsion of Vital Records, P.O. Box 68760, Physician/Medical 88 use signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 4lo 3 Probably 4 Unknown by 24b. Wara eutopsy findings available prior to Completed 24e. Was en autopsy performed? completion of cause of death? s certificete hes b director, pege 2 s 1 Yes 2/2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medicel examiner? Be 26. Piace of Deeth (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Menner of Death 28c. Injury et Work? 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Naturai 5 Pending efter deeth. 1 Yas 2 No investigation 2 Accident 6 Could not be dataminad 3 Suicide 28a. Placa of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 24 hours e Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end pieca, and due to tha ceusa(s) end menner as steted.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daeth occurred et the time, date end piaca, end due to the cause(s) individual manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29b. Signeture and the of certifier 29c. License number 3 3 0 3 9 29d. Date signed (Month, Dey, Year) 10/03/00

Conf Rd. Snite 201; Baltima, no VIDP

30. Nama and address of person who completed cause of deeth (item 23a) (Type, Print)

MA

4000

32. Registrer's Signeture

04

WISTER,

1 2 2000

Milah

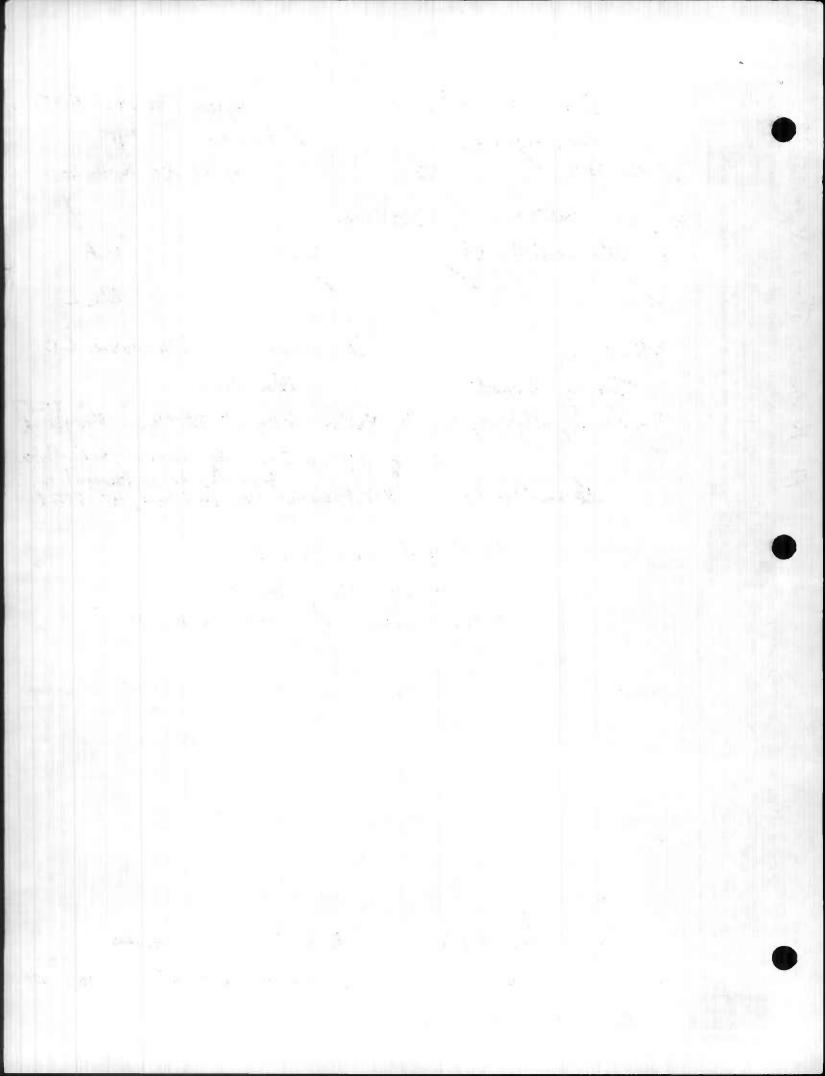
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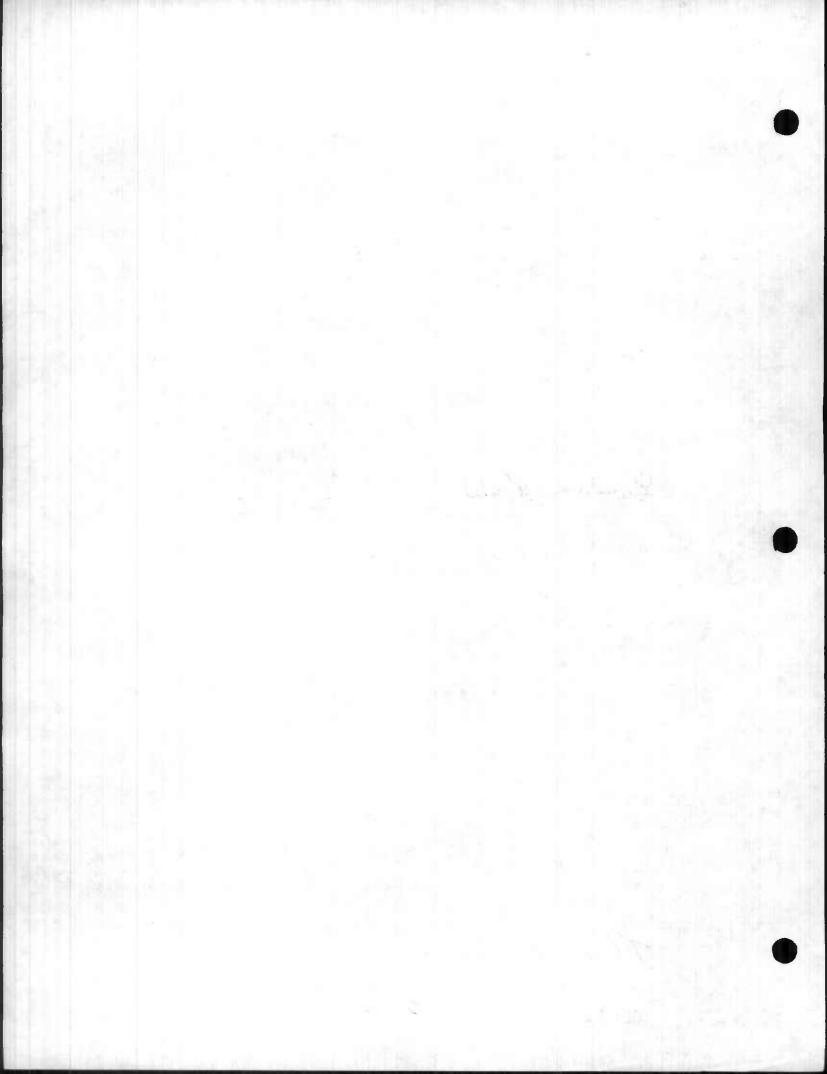
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State

Registrar



-57	64-510			State of N	/larylan		artment of I		and M		giene Reg. No.	00	3216	6
		_	1. Decedent's Name (First, Middle, La	ist)						2. Date of De	ath	Wana	3. Time of D	Deeth
	Physiciar /Medica		CLARENCE EDWARD	RICHARDS	ON					OCTOBE	R 9,	2000	1520	PM
	Examine	-	4a Facility Name (If not institution, give	e street and numbe	r)	4				cation of Deatl	4c. C	ounty of Deet	h	
	· ·		SINAI HOSPITAL				K Hadas 1 Vans	BALT'I				N/A		
	Funeral			Sex 7. A 1 ◯ M 2 □ F		last birthday) Yrs.	Months Days		Min.	8. Date of Bir (Month, De		Co	hpleca (State or untry)	Foreign
_	Director	-	214-16-7468 Usuel Residence of Decedent		81	_				9-17-	1919	MI),	
	Man In		10a. Stete 10b. County			y, Town or Lo							10d. Inside City	4.0
	Starf a	Director	MD. N/A		BA	ALTIMO							1 XYes	2 🗌 No
	or 28s-f	5	10e. Street end Number				10f. Zip Code	100			10g. Citize	n of Whet Co	untry?	
	ne 23	erai	3404 FORREST PAI	RK AVE.	t Ever in II	C 12 1	2121 Was Decedent of		ain? (Sne	city Yes or No	US	A . Raca - Ame	rican Indian	
0	n 8 H	runeral	11. Maritel Stetus 1 ☐ Never Merried 2 ☑ Merried	Armed Forces	3?		r Yes, specify Cut	oan, Mexican	, Puerto F	Rican, etc.)		Black, White	e, etc.	
302	E 42 7	100	3 Widowed 4 Divorced	tf Yes, Give Yeer or Dates	s:		1□Yes 2∏No	Specify:			Si	pecify: BLA	ACK	
21215-0020	T2 h	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Dece (Give	dent's Usuel Occu kind of work done DO NOT use retire	pation during most	of working	ng	16b. Kind	of Business/	Industry	
112	within one.	dwo	Elementery/Secondary (0-12) -12-	College (1-4o	r 5+)		ABORER	90)			ACCES	(DIV DI	A NYTT	
9	四五首章		17. Father's Neme (First, Middle, Last			La	ADUKLK	18. Mothe	r's Neme	(First, Middle		ABLY PI	JANI	
lan	fental fental fest fic ev	0 136	JOHN SKINNER					BERT	HA R	ICHARDS	SON			
Maryland	and h		19e. Informent's Neme/Reletionship (Type, Print)		19b. Meilin	ng Address (Stree	et end Numbe	er or Rura	l Route Numb	er, City or 1	Town, State, 2	Zip Code)	
20	and and a suith a suit	-	NORMAN RICHARDS	SON(SON)	1		LAUREL	DR. BA	LTIM			200		
ore	I to H		20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □	Removel from Stet		lece of Dispo emetery, cret	sition (Neme of metory or other ple	ece)		Dete	20c. Loce	tion - City or	Town, Stete	
Baltimore,	the Pa		4 Donetion 5 Other (Special	(4)			E NATIONA						E, MARYI	LAND
Ba	Department of the partment of		21. Signature of Funeral Service Lice	1/200	al		2. Name end Addr 721-27 N						ZI AND 21	217
	TO THE REAL PROPERTY.	+	23a. Pert1. Enter the disease, or com shock, or heart failure. List only	polications that caus	ed the death							E, FIAR	Approximate	
	Physician /Medical Examiner	9	Immediate Cause (Final disease or condition resulting in death)	. Mul	tyle	- lug	wes		Ų.		4		Onset and D	eath
	ysician and he burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	Due to (o	r es e consec	quence of):	7	***			1		
68760,	licate be physicials the bur	edical	Cause (Diseese or Injury thet initieted events resulting in death) Last	C	Due to (or	r as a consec	juence of):	Ħ				1		
Box	at the death certifical d by the attending phi etached for use as th			d										
	death of for	200	Part II. Other eignificant conditions of	contributing to death	but not resi	ulting in the u	nderlying cause g	iven in Pert I		23b. Dld	tobacco u	ae contribute	to the cause of	f death?
P.0	that the de led by the a detached to									10	Yes 2	No 3 P	robably 400	Inknown
Records,	een sign	leted by						7.9-4		24a. Wes	en eutops ormed?		Were eutopsy fir eveileble prior to completion of ca	0
Re	has has	dui								15	¥es 2□		oldeeth? 1.27 Kes 2□ I	No
Vital	iclan: The certificate rector, pag	D	25. Was case referred to medical					26. Plece	of Deeth	(Check only			7 20.	
	Physician: this certific ral director,	0	examiner? 1 X Yes 2 □ No	Hospitel:	itient 2	ER/Outpeties	nt 3[XDOA O	ther:		me 5□Resi		Other (Spe	city)	
n of	After this funeral		27. Menner of Deeth 1 Neturel 5 Pending	28a. Date of In (Month/L	jury Day Year)	28b. Time o	28c. Inje	ury et ork?	,	28d. Describe	how injury	occurred Ca	byet	1.
Division	rs after death. al Director: After ted in by the funer	Call	2 Accident investigetion 3 Suicide 6 Could not be	14//	0	1425	ME	Yes 2		Leli	ula	ccide	tower	elm
N	after death Director: / d in by the		4 Homicide determined	Zoe. Piece of I	etc. (Specif	()	reet, factory, office				Street end wn, State)	2113NG	Trel Route Numb	Horek
	Hospital 24 hours a Funeral I stely filled		29a. Certifier 1□ CertifyIng Pt	nyelclan: To the bes		wiedne deet		time dete en	d place	and due to the	CAUSA(S) A	nd manner es	lopy a	-19
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in t	5	(Check only one) Medical Exam	miner: On the basis end menner:	of examine	tion end/or in	vestigation, in my	opinion, dee	th occurr	ed et the time,	date end p	lace, end due	to the cause(s))
	within 2 To the comple	3	29b. Signature and title of certifier					nse number				signed (Mont		1.75
			Theolow	11.V:	- A 2	40		OCME		1 - 1-	OCTO	BER 10,	2000	
	40		30. Name and eddress of person who		de th item			T.L.Y						
			THEO DOPE N		strada Class		Penn St	reet,	Balt	imore,	Mary]	land 21	1201	
	State	-	31. Dete filed (Month, Dey, Year)		strer's Signe	L'S	poak	2						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Dete of Death Yes **Physician** Cole William 2000 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Dea Examiner Medical unapoles mettrude Under 24 Hrs. 8. Date of Birth Hours Min Moeth, Dey, Year) 12 54 Ctober 3, # Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number Funeral Months 110 M 2□ F NA Director -0 **Usual Residence of Decedent** 10a. State 10b.,County 10d. Inside City Limits Ellicott 1 Yes 2 No TOWATO Director 10f. Zip Code 10g, Citizen of What Country? 6 Enger Ct

12. Was Decedent Ever in U.S. 21042 0321 Inited Berne 23a 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Rever Married 2 Married 1□ Yes 2NNo Baltimore, Maryland 21215-0020 "natural", or Specify Whitz P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complete Hygiene. Elementary/Secondary (0-12) NA NA V)(2 permit. Pages 1 and 2 should be liled Department of Health and Mental Hygie Important: If Isen 27 is marked other 1 any injury or other treumatic event. In 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 88 -i Anhard Vane Kichard 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Ellicott City, Md 210/2 Dane Rianhard 10321 lather 20b. Place of Disposition (Name of cemetery, cremetory or other 20a. Method of Disposition Dete 20c. Location - City or Town, Stata Burial 2 Cremation 3 ☐Removel from State ST. JOHNS 10/10/00 Ellicott City CEMETERY 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral S old Columbia Pilas SLACK FUNERAL HOME P.A. Ellicoft City 21043 why or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sits only one cause on each line. Approximete Interval Between Physician /Medical Immediate Cause (Final disease or condition resulting in death) pirator Examiner Examine physicien end s the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated assets) Dua to (or es a consequence of): Box 68760. Physician/Medical Cause (Disease or Inju that initiated events resulting in death) Last Due to (or es a consequence of) 087 Part II. Other algarificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ð 24b. Were eutopsy findings available prior to completion of causa of death? 24a. Wes en eutopsy performed? Completed 1 Yes 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: ↑ Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To this 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? After t or Attending To the Hospital or Attending within 24 hours effer deeth. To the Funeral Director: Afte completely filled in by the fune Natural 5 Pending investigation NA 1 Yes 2 No NA NA 2 Accident 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 047158 MD of person who completed cause of death (Item 23a) (Type, Print) Yann MID conn Organi, Day, Xear) 2000 32. Begistrar's Signature State Registrar

Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 34 AM **Physician** M 2000 /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Joseph Richey Hospice Baltimore If Under 1 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Deys Min. 1□M 2XF Months Hours 213-22-6320 Director August 21, 1928 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo MD. Baltimore Baltimore, 10e Street and Number 10f. Zio Code 10g. Citizen of Whet Country? 1238 Oakland Terrace Road 21227 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11 Meritel Status Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 XMerried 1 Yes 2 No ò Specify: White Baltimore, Maryjand 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced netural. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Operator C & P Telephone Co. 17. Father's Neme (First Middle Last) 18. Mother's Name (First Middle, Maiden Sumame) th and Mental I. Be Charles Campbell Ivy Plant 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haalth em 27 i Herman A. Schaeffler-Husband 1238 Oakland Terrace Road, Baltimore, Maryland21227 If Hem 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State October 11,2000Elkridge, Maryland 1 Buriel 2 Cremetion 3 Removel from Stete Department of Important: If any injury or once. Meadowridge Memorial, Park 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signature of Funeral Service Licenses Witzke Funeral Home, Inc. Lemmer 1630 Edmondson Avenue , Catonsville, Maryland21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deatl **Physician** METASTATIL PANCREATIC CANCET Immediete Ceuse (Finel diseese or condition resulting in death) /Medical AND SCHAEFF Examiner Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): physician Physician/Medical eut. Due to (or es e consequenca of): 88 USB signed by the e Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en autopsy performed? hes page 2 1 ☐ Yes 25 No 1 Yes 2 No funeral director. 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE P 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Maturel 5 Pending Investigation death. 1 Yes 2 No 2 Accident after deat Director: 6 ☐ Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 4 Homicide To the Hospital within 24 hours To the Funeral Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. edical 29a. Certifier completaly (Check only one) A 29b. Signet end title of continu 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Registrar **DHMH 16 Rev 6/95**

R. ANANDA

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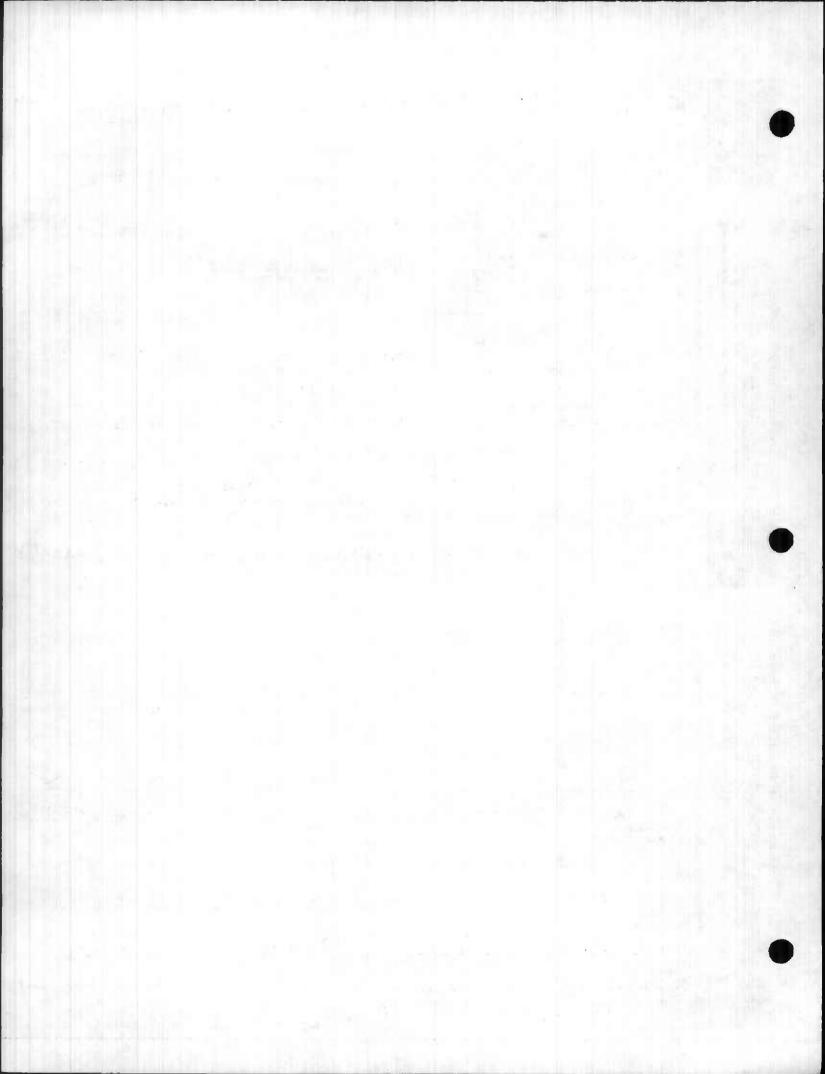
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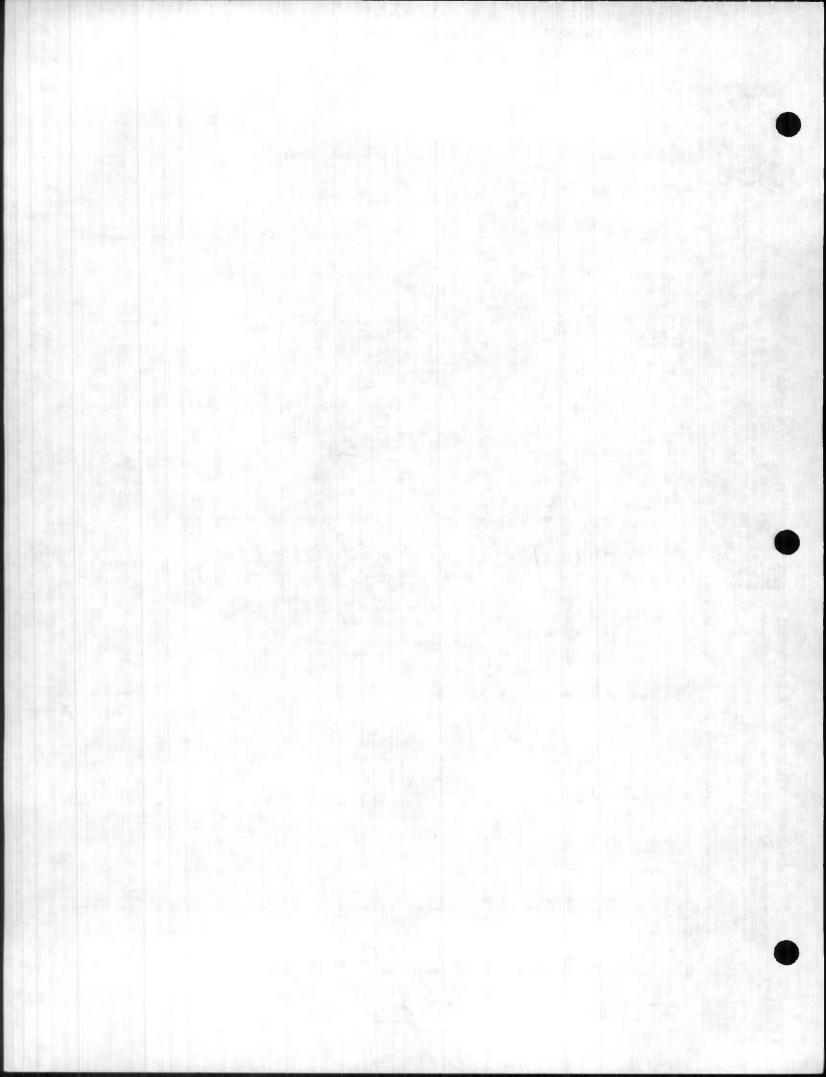
32. Registrat's Signeture

KILISHNAN



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 3 2 1 6 9

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	<i>)</i> .		5. Social Security Number 6. Se		(In vrs la	st birthday)	If Under 1 Year	Baltimo			timo	
	Funeral Director			ØM 2□ F	81		Months Deys	Hours Min.	8. Date of Birth (Month, Dey Sept. 5,	Year) 1919	Mary	oleca (Stete or Foreign otry) ILand
	pung to se		10a. Stete 10b. County		10c. City,	Town or Loca	tion				1	Od. Inside City Limits
	May Held	tor	Maryland Baltin	nore			Bal	timore				1 ☐ Yes 2 ☐ No
	or 28s	Sirec	10e. Street and Number			1	10f. Zip Code			0g. Citizen of W		
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21215-0020	urs after death with the Maryta alf, or thems 23s or 28s-f sho Exertiner must be notified at	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decadent E Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:		10	is Decedent of H res, specify Cubi	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		, White,	ean Indien, etc. uite
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Maryland	d be ental	o Be	Andrew Stran					Mertle		<i>jers</i>		
ary	shoul man ments	F	19a. Informant's Name/Relationship (T)	ype, Print)		19b. Mailing	Address (Street	end Number or Ru			Stata, Zip	Code)
ž	allh a 27 is r tra		Herbert A. Stran,	Jr. (50	n)	7224 S	unshine	Ave., Ki	ingsville	2, MD 2	1087	
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Bai	Departiment in portion any in		21. Signature of Funeral Service Licens Butter (1)	wille	u	Sc	himunek 05 Bela	Funeral ir Rd., B	Home, In	ic.	1236	
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	Examiner		Immediate Cause (Finel disease or condition resulting in death)	a / true	Muti	10 1) 6	20701	Carci	numa		10	of years
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	icate be assocuted physician and s the burial-transit	Examiner	Sequentially list conditions,	b	Due to (or	as a conseque	ince of):	23.53				
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	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate hi completely filled in by the funeral director, pege	edical Certification:	(Check only one)	elcien: To the best of iner: On the basis of and manner ste	examineti	on and/or inve	stigation, In my	opinion, death occu	rred at the time,	date end place, a	nd dua t	to the cause(s)
	Within To the	2	29b. Signeture and title of certifier				29c. Licens	se number		29d. Date signed	(Month,	Dey, Year)
	X	1	Han V. Slear	anmo			D3.	3231		10/11/	10	
	5	`	30. Neme and address of person who co					20E Ral	timaka	MD 01	236	
	Stat	0	Dr. Ian K. Slepi 31. Date-filed (Mooth, Day, Year)	32. Registra			, succe	203, Da	milore,	MU ZI	230	
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** October Virginia J. Scott 2000 0040 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Fallston Harford Fallston General Hospital If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Dey, Year) 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 1 M 2 XF Months Days Hours 79 Yrs. 213-16-4281 Nov. 8, 1920 Director Maryland Usual Rasidence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f ahow traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Perry Hall Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 8 U.S.A. 9903 Fox Hill Road 21128 Herra 23a by Funeral filed within 72 hours after death 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas ≥ 2 (X) No If Yas, Give Yaar or Dates: 14. Race - American Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 1 Never Married 2 Married ò Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White. 3 ☐ Widowed 4 ☐ Divorced "natural". Be Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) el Hygiene. Elemantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 12th Grade 18. Mothar's Nama (First, Middla, Maiden Surnama) 17. Fathar's Nama (First, Middle, Last) 12 should be fill h and Mentel H is marked oth Lottie V. Sterner John W. McCartin 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) (Grand-2614 Crabapple Road, Baltimore, MD Mrs. Julie McDonnell daughter) Department of Haalth Important: If Item 27 other Baltimore, 20b. Place of Disposition (Nema of cematary, crametory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Peges 1 1 Burial 2 Cramation 3 Removal from State 6 10/13/00 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Moreland Memorial Park any injury 22. Nama and Addrass of Facility
Schimunek Funeral Home, Inc. 21. Signature of Funeral Sarvice Licensee Buar a levelle 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Batween Onsat and Daath Physician Immediata Causa (Final disease or condition rasulting in death) /Medical · ACUTE RESPIRATORY DAYS **Examiner** Dua to (or es a consaguanca ot): SEVERAL Physician/Medical Examiner PULMONARY MONTHS The lew requires that the daeth certificate be executed Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated evants resulting in daeth) Last Dua to (or as a consequence of) Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco usa contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown signed by HY PERTENSION Division of Vital Records, þ 24b. Wara autopsy findings evaileble prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? this certificate hes 1 Yes 2 No 1 □ Yas 2 □ No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to 25. Was casa rafarred to medical 26. Placa of Daath (Check only ona) Hospital: 12 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No Medical Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending Invastigation 1 Natural 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Pleca of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and menner as steled.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifier 2000 30. Neme and address of person with completed causa of death (Item 23a) (Type, Print) MD 21014 ABHYAVKAR I NORTH AVENUE BEL AIR VIJAY M. 32. Registrar's Signature 31. Data filed (Month, Day, Year) OCT 1 2 2000 State

DHMH 16 Rev 6/95

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Lavina Rae Stotelmyer Oct 80 2000 6:25 am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Hospital Center Hagerstown Washington 8. Date of Birth (Month, Day, Year) June 20,1951 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Deys Months 177-42-2830 1□M 2NF 49 Pennsylvania **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington Maryland Hagerstown 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Winter Street Apt. 1 21740 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bernard A. Peters Betty L. Coffey 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Harris/ Sister 2 Cross Creek Ct Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Ø Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc10/13/00 Beltsville, MD 21. Signature of Funeral Service License 22. Name end Address of Fecility CAFA Stephen D. Lohrmann P.A. Hondesly lama 8717 Green Pastures Drive Baltimore, MD 21286 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac arrest 2 days Due to (or es e consequence of): Chronic obstructive pulmonary disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es a consequence of): Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tohacco use contribute to the cause of death? 1 | Yes 2 | No 3 No Probably 4 Unknown Morbid obesity 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 🛣 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospitat: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

P

Completed

Funeral

Director

filed within 72 hours after of Hygiena. Ither than "natural", or Nei

Pages 1 and 2 should be nent of Health end Mental

If Nem 27 Is or other tree

permit. Page Depertment of Important: If any Injury or once.

Examiner Physician/Medical Completed Be Certification: To

physician and the burial-transit The law requires that the death certificate be axecuted Box 68760. U80 88 P.O. Division of Vital Records, certificate has Attending Physician: this funaral s efter death. filled in by 8 Hospital 24 hours

completely To the I

State Registrar

DHMH 16 Rev 6/95

4 Homicide

Chronic renal insufficiency Diabetes mellitus Respiratory failure 25. Was case referred to medical examiner? 1 Yes 2X No 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 K) Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, lerm, street, lectory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

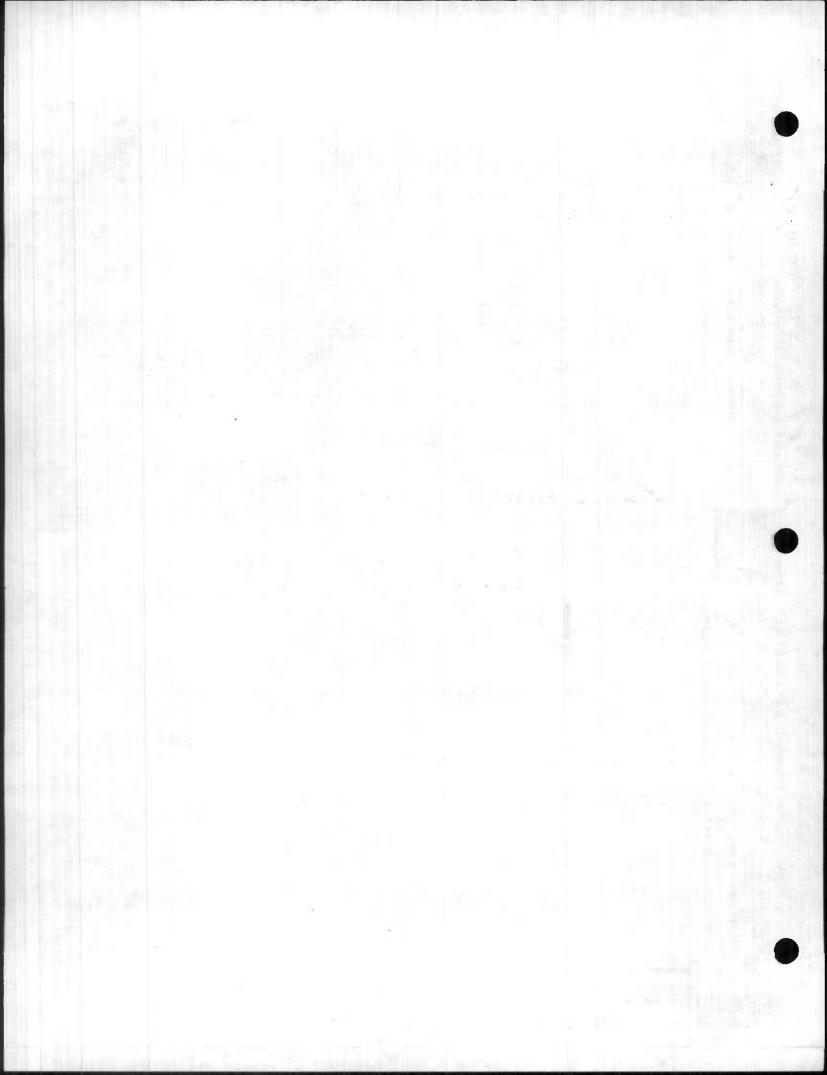
Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified BLO D27898 Oct 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Pennsylvania Avenue Hagerstown, MD 21742

Francisco L. Andrade, M.D. 31. Date filed (Month, Day, Year) -32. Registrar's Signature 2000

sack



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Deeth Decedent's Name (First, Middle Da **Physician** rie ,2000 ctober /Medical 4c. County of De (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner more If Under 24 Hr 8. Date of Birth 6. Sex 7. Age (In yrs. last birthdey) 9. Birthplace (Stele or Foreign 5. Sociel Security Number **Funeral** Days 10 M 20 F 219-80-9460 Usuel Residence of Decedent Yrs. Director permit. Pegas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "natural", or items 23s or 23s-f show any injury or other treumstic event, he we do a more man be notified at energy. 10a State 10h Counts 10c City Town or Location 10d. Inside City Limits 1 Yes 2 □ No Funeral Director aryand 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No if Yes, Give Yeer or Detes: 14. Reca American Indien 11. Maritel Stetus Bleck. White, etc. 1 ☐ Never Merried 2 ☐ Married 21215-0020 1 ☐ Yes 2 ◯XNo Specify: Completed by 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT upe retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Cotlege (1-4or 5+) C Baltimore, Maryland 18 Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) mother mal WOOD 10. 20b. Pleca of Disposition (Name of cemetery, cremetory or other pleca Dete, 20c. Location - City or Town, State Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete 10 2000 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Ligensee 22. Name and Address of Facilit F Joseph 2222 V unera AVE Balto. Vld. 2121 th W. Nor Thier the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, or hear feilure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical YEARS LANCER Examiner Due to (or es e consequenca of) Physician/Medical Examiner physician end the burial-transit thet the death certificate be asscuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieled events resulting in deeth) Lest Due to (or es e consequenca of): Box 68760. Due to (or es e consequenca of): USO BS I 23b. Dtd tobacco use contribute to the cause of death? Part If. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records. P.O. signed by t 1 Yes 20 No 3 Probably 4 Unknown Completed by The law requiras 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? certificata has 1 Yes 2 No 1 Yes 2 Di Division of Vital or Attending Physician: 25. Wes case referred to medical edicai Certification: To Be 26. Place of Deeth (Check only one) Other: 4 | Nursing Home 5 | Residence 6 Dother (Specify) MOTHERS HOME 1 Yes 2 No 2 ER/Outpetient 3 DOA 1 Inpatient After this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 1 Naturel 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 2 No 1 Yes death. 2 Accident aftar death 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Pleca of tnjury - At home, ferm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only

State Registrar

29b. Signeture and title of certifier

31. Dete filed (Month, Day, Year)

ANANDA KRISHNAN

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
ANANDA KRIJHNAN EN N. EUTAW ST

DHMH 16 Rev 6/95

32. Registrer's Signature

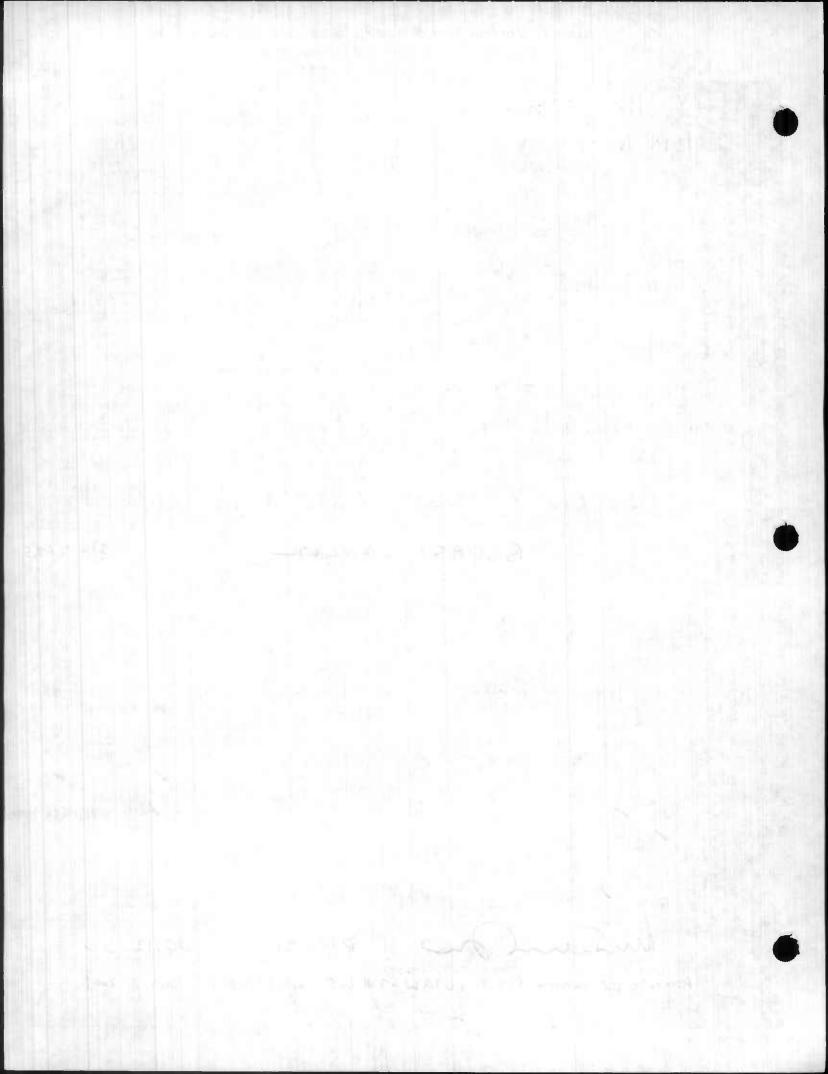
N. EUTAW ST # 305 BASTIMONE

29c. License number

29d. Date signed (Month, Dey, Year)

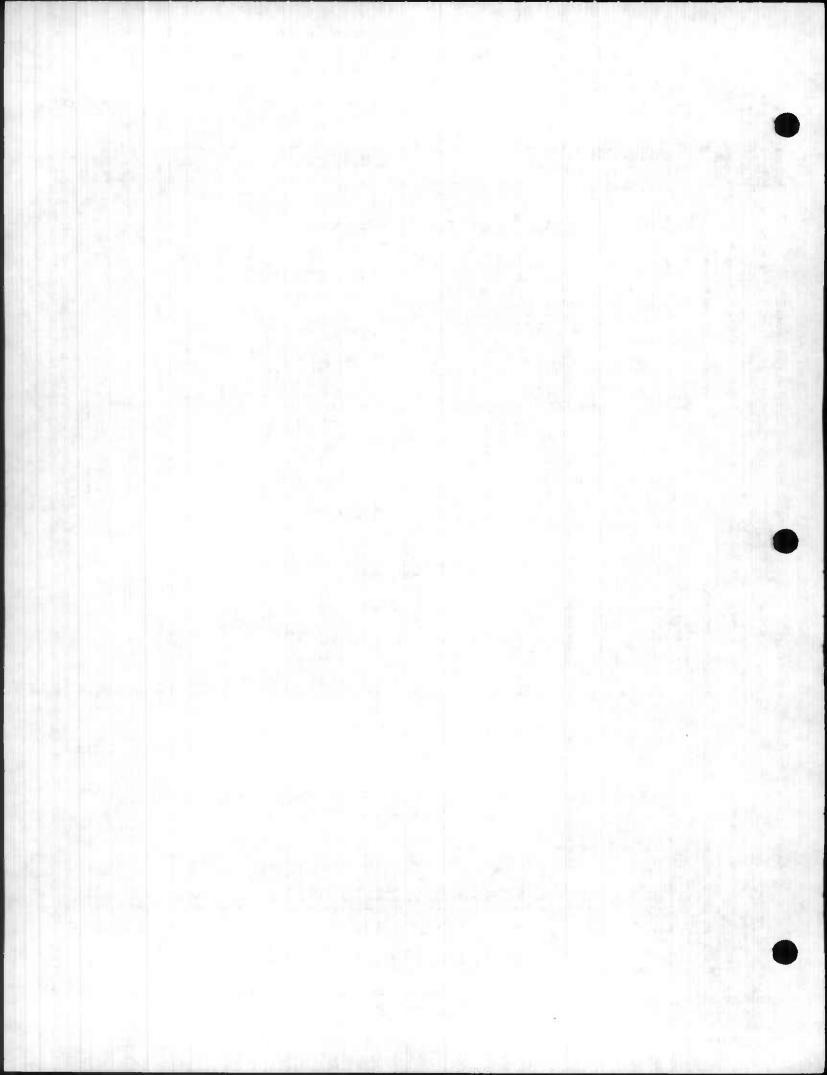
10.12.00

NO 21201



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** ser 10,2000 /Medical 4b. City, Town, or Location of Death Facility Neme (If not institution, give street end number) 4c. County of De Examiner tue If Under 24 Hrs. more If Under 1 Year last birthday) 8. Dete of Birth (Month; Day Birthplece (State or Foreign **Funeral** Deys Months Hours Min. 36 1□M 20 F Yrs Director Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director nore Maryland 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 234 Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. or items 12 11 Meritel Stefus filed within 72 hours after Yes 2 No 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specity: Be Completed by 3 Widowed 4 Divorcad 4 merican Year or Dates 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life, DQ NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) ry/Se condery (0-12) other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name, (First, Middle, Maiden Surneme) ie marked of Pages 1 end 2 should be 19a. Informent's Name/Relationship (Type, Print) (Brother 19b. Meiling Address (Street end Number or Rurel, Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Heelth a Important: If Item 27 is any injury or other tra 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1. Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name end Address of Facility uneral Joseph North AUR Md. 2/21 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart fallure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel One month 9 disease or condition resulting in death) **Examiner** Due to (or es e consequenca of) Physician/Medical Examiner The lew requires that the death certificate be axecuted Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lasf Due to (or as e consequence of): use as the bunal-tran P.O. Box 68760, Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? detached 1 Yes 2 No 2 3 Probably 4 Unknown Division of Vital Records, Be Completed by 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? page 2 1 ☐ Yes 2 No 1 Yes 2 No this certificete or Attanding Physician: 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 2 No 5 Residence 6 Other (Specify) 1 Yes Medical Certification: To 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Time of After 5 Pending investigation Neturel after death. 1 Yes 2 No 2 Accident the 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral L Hospital 29a Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Dey, Year) 29b. Signeture end fitte of certifij 29c. License number 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Registrar



Please Type or Print in Black indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Year **Physician** HOWARD SOFTLEY 7: 45 am Oct 9 2000 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Catons ville
If Under 24 Hrs. 8. Date of Bi Charlestown Centar Baltimore Care If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□ F 309-09-2296 Yrs Director Dec 28, 1910 NEB Usual Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2¥ No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Herna 23a or 719 Maiden Choice Lane 21228 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: Specify: white à 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiena. College (1-4or 5+) Elementery/Secondary (0-12) 12 permit. Pagas 1 and 2 should be filed will Department of Haelth and Mental Hygiens Important: If frem 27 Is marked other that any lijury or other traumatic event, traumones. engineer chemical 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Alfred Softley Cleo P. Fauguet 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Thomas Softley/son 752 Cactus Court Millersville, MD 21108 20b. Place of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, Stete cemetery, crematory or other piece) 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 X Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee Ronald, Sy Wade Director 22. Name and Address of Fecility
State Anatomy Board 655 W. Baltimore Street Will 110 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final oronary Artery Disease disease or condition resulting in deeth) Year) Examiner Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical that initiated events resulting in deeth) Lest Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Cerebro Vascular Acerdent þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? Completed 1 Yes No 1 ☐ Yes 2 No Vital 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Medical Certification: To of this 28e. Dete of Injury (Month, Day Year) 27. Manner of Death To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the tunera 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation Neturel 2 Accident 1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29e, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier October 9,2000 30. Name end address of parson who completed cause of death (Item 23a) (Type, Print) Julus choicefane , Catorsville, MD, 21228 Maidle Andres 5 algran
31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture

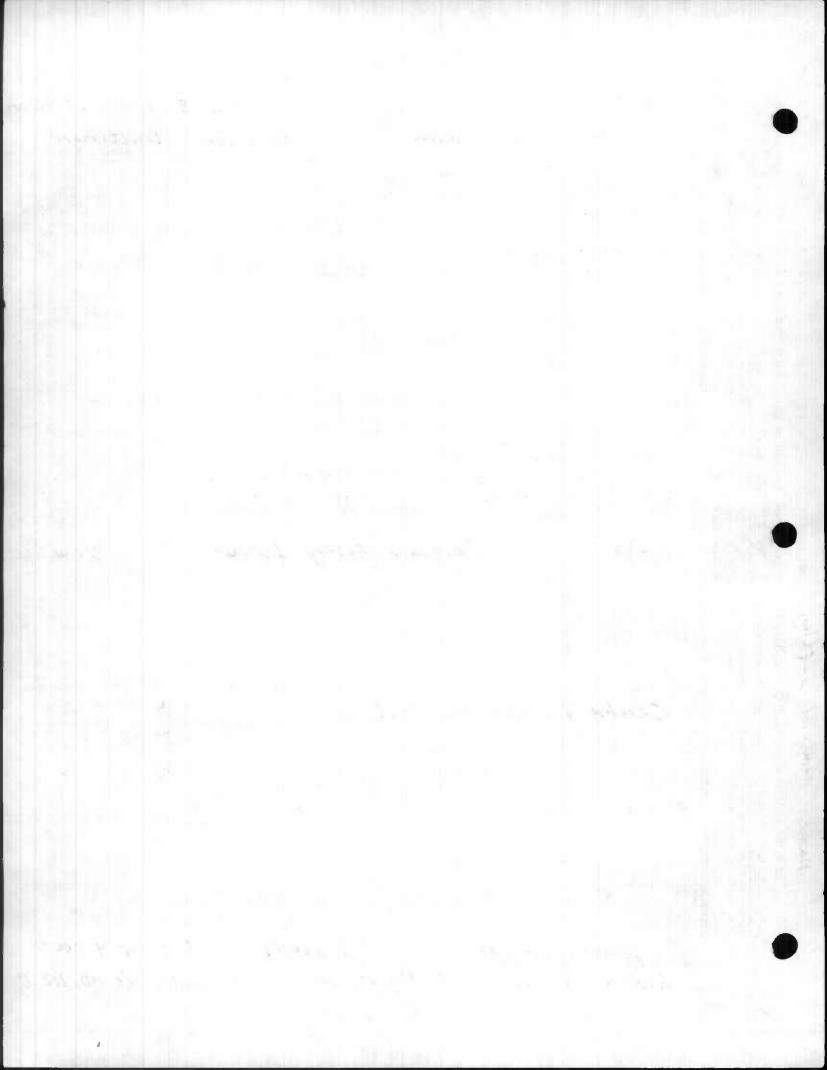
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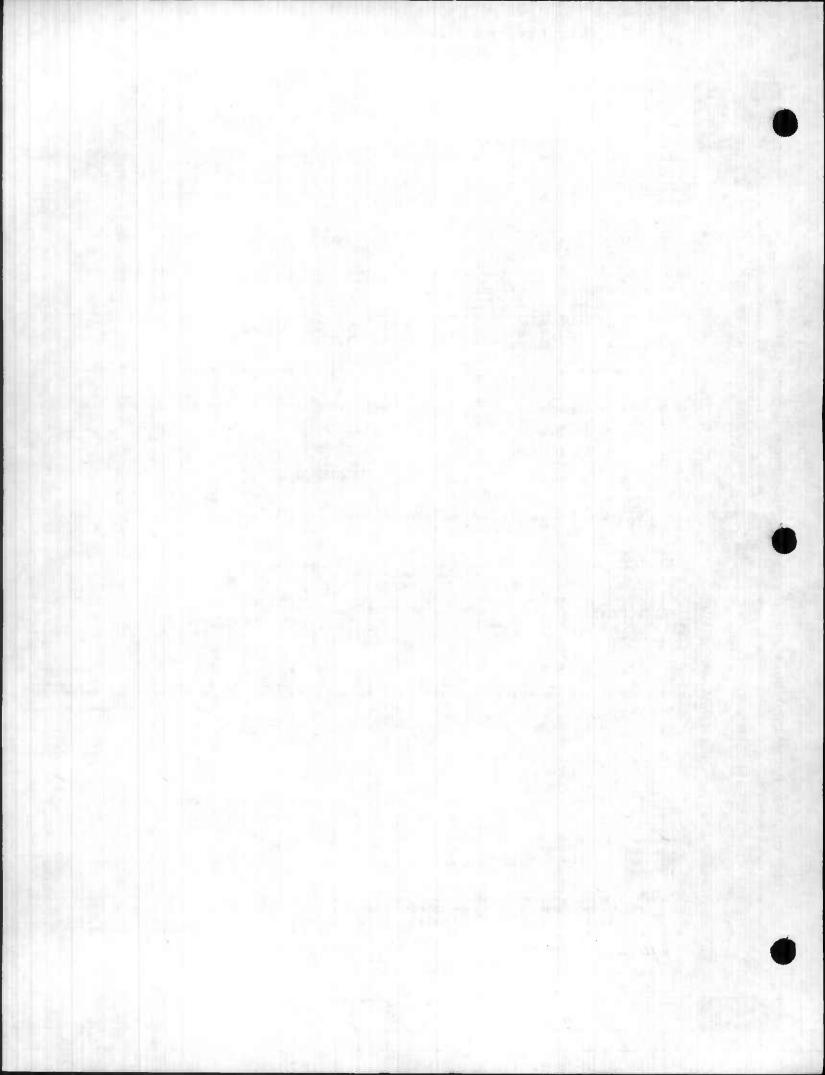
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State of Maryland / Department of Health and Mental Hygiene

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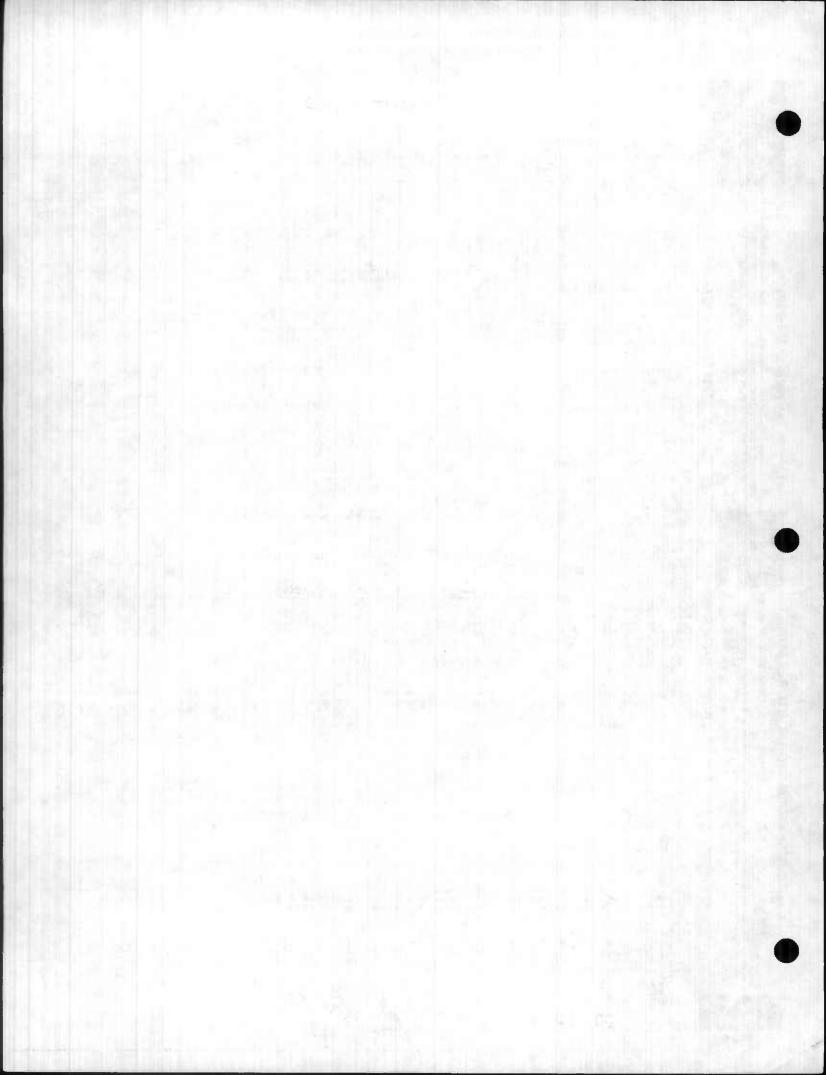
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10	John Yeakel					Theresa	McEnane	У		
	19e. Informant's Name/Reletionship	(Type, Print)	19	b. Mailing Ad	dress (Stree	t end Number or R	ural Route Numbe	r, City or Town,	Stete, Zip Co	ode)
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	4 Donetion 5 Other (Spec		Ceuai			ess of Fecility	11/2000	Darcinc	ite, M	1.
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je la	resulting in deeth)	CONGE	Due to (or es e			LURE			1	
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Cert	4 Homicide determine	building, et	c. (Specify)				City or Tow			- 783
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×	29b. Signature end title of certifier	Я			29c. Licer	se number		29d. Date signe		ly, Year)
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	30. Neme end address of person who	completed cause of d	eeth (Item 23e	(Type, Print)	n Hil	ז סא	Raltima	re Ma	7 27	234
	Serena R. No.			saly.	плл	I KU.,	Dartino	TC, MC	212	, , , ,
State	31. Dete filed (Month, Dey, Year)	32. Registr	er's Signeture	La	1	16				



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			Certif	icate of	Death	F	Reg. No.		2110
	1. Decedent's Nema (First, Middle, Last)				2. Date of Dea	nth Dev	Year	3. Time of Death
Physician /Medical	SUNANDA		SHANT	HIKUM	IAR	OCTOBER		2000	12:15 PM
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Funeral Director	214-66-41/2			Under 1 Yaar onths Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan. 06		9. Birthpled Country India	ce (Stete or Foreign
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\$ 8 B	10e. Street end Number 6516 Dolphin Cour	t	1	0f. Zip Code	21061		10g. Citizen of W USA	hat Country	?
ofter death v	11. Marital Status	12. Wes Decedent Ever in t Armed Forces?	J,S. 13. Was	Decedent of H	lispanic Origin? (Span, Mexicen, Puert	pecify Yes or No- o Rican, atc.)	14. Race Black	- American k, White, etc	
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Te, N 1 and 1 Health tem 27	20e. Method of Disposition		Plece of Dispositio	n (Neme of		Dete	20c. Location ·		
Baltimore, Maryland 212-1 permit. Pagas 1 and 2 should be filed within Department of Health and Mental Hygiana. Important: If item 27 is marked other than any injury or other traumatic event, the Mental. To Be Compl	1 XBurial 2 ☐ Cremetion 3 ☐ 6 4 ☐ Donation 5 ☐ Other (Specify)	Ce	dar Hill	Cemete	ry 10/0	9/2000	Baltimo	re, Mo	i
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Division o To the Hospital or Attending Ph Within 24 hours aftar death To the Funerel Director: Aftar th completaly filled in by the funerel Medical Certification:	2 ☐ Accident investigation 3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injury - At I building, etc. (Spec	nome, term, street, ify)			28t. Location (S City or Tox	Street end Numb vn, Stete)	er or Rurel I	Route Number,
despital 4 hours 6 tunerel 1 aly filled Ical Ce	29a. Certifier (Check only 2 Medical Exam	sician: To the best of my kn ner: On the basis of examin end menner steted.	owledge, death oc	curred et the ti	me, date end plece	, end due to the	cause(s) end me	nner as stat	ed. he ceuse(s)
the Hospi thin 24 hound the Fune mpletaly fill		end menner steted.		29c. Licens			29d. Date signed		
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10	30. Nema end eddress of person who co	ompleted ceusa of death (Ita	04.0	600	N. Wol	fe St B	Baltimon	OM	21287
State Registrar	31. Dete filed (Month, Dey, Year)	32. Ragistraris Sign	atura B	500	nks				



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Helen Irene Snapp 07:45 AM Oct 9, 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Columbia Howard Howard County General Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** Min 1 M 2 F Months Days Hours Yrs. Director 69 219-28-1313 Apr 1, 1931 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Herne 23s or 28s-f short 1 Yasy 2 No Director plane. r than "natural", or thems 23s or 28s-f the Medical Examiner must be notifie Maryland Ellicott City Howard 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? 21043 U.S.A. 4721 Salterforth Place Funeral 12. Was Dacedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes x2 No Specify: Specify: by 3. ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry be flied within Elementery/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 86 Mental Helen Leech Eli Tschudy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 a Health Hem 27 h 4721 Salterforth Place Ellicott City, Maryland 21043 Susan Vizzini 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 □ Cramation 3 □ Removal from State
 Donation 5 □ Other (Specify) 10/12/00 Sykesville, Maryland Lakeview Memorial Park 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. aur 3871 Old Columbia Pike Ellicott City, MD 21043 MOIII3 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Intracranial Hemmorhage days **Examiner** Due to (or as a consequence of): Examiner Hypertension To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deeth.

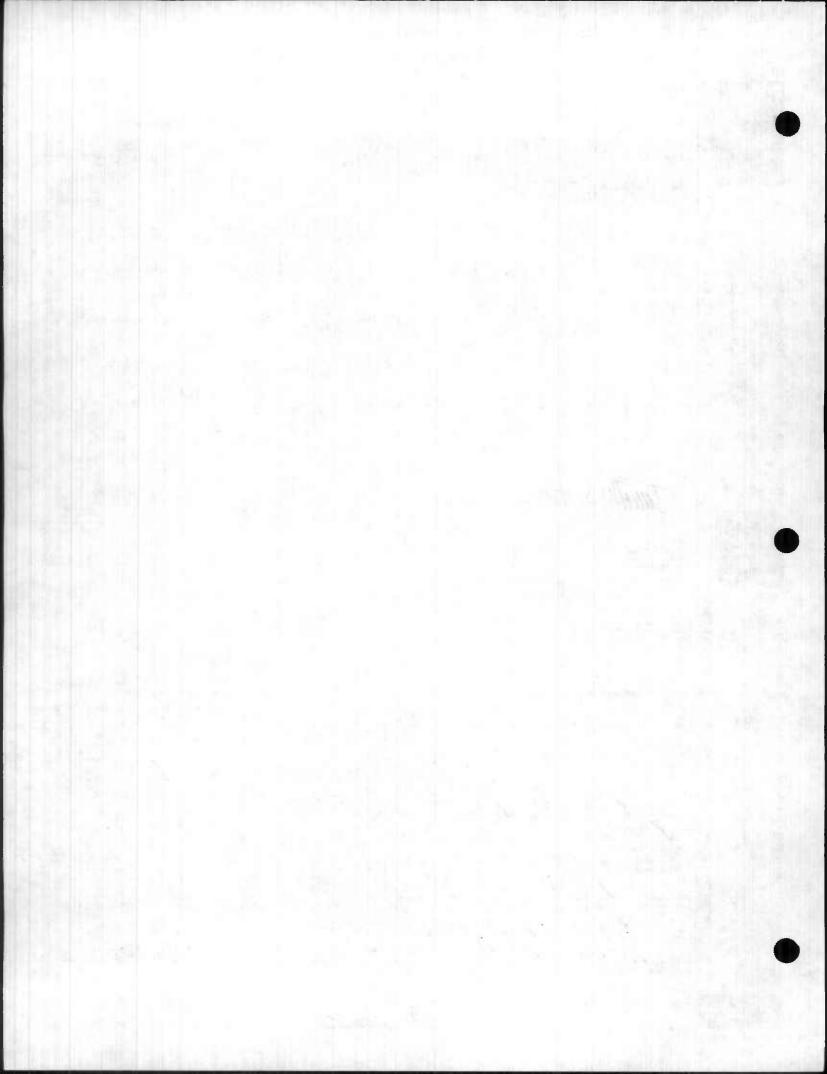
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Disease or injury that initiated events Due to (or as a consequence of): 68760. Physician/Medical Dua to (or as a consequence of) resulting in death) Last Box (P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by Completed 24b. Were autopsy findings 24a. Was en eutopsy performed? available prior to completion of ceuse of death? 2M No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medicel exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No No Inpatient 2 □ ER/Outpatient 3 □ DOA 10 27. Manper of Death Certification: 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 5 Pending invastigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) Medicai 29a. Cartifier all manner stated. 29b. Signatura applica 29c. Licansa number 29d. Date signed (Month, Day, Year) D41697 30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print) Stephen Grill, M.D. 11055 Little Patuxent Parkway Columbia, Maryland 21044 Par 2000 Degistrar's Signature State

DHMH 16 Rev 6/95

Registrar

souls



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Year **Physician** George Raymond Saunders October 03:50 AM 10 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** St. Agnes Hospital Baltimore N/A H Under 24 Hrs. 8 Date of Birth (Month, Day, Year) If Undar 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days 1 ☑ M 2 ☐ F Vrs 213-52-1062 09/21/1949 Director Maryland Usual Rasidanca of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits N/A Baltimore City Maryland 1 1 Yas 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 2809 Georgetown Road 21230 United States Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S Armed Forcas? 1 ∑Yas 2 ☐ No If Yes, Giva Yaar or Datas: 1 ☐ Navar Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Manager Production 12 permit. Pages 1 and 2 should be file. Department of Health and Montai Hy important: if them 27 is mentant Hy injury. 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be William Franklin Saunders Alta Marie Evens 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Jeanette Saunders 2809 Georgetown Rd. Baltimore, MD. 21230 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 10/13/00 Elkridge, Maryland Meadowridge Memorial Prk. 21. Signature of Funaral Sarvice Licenses 22. Nama and Address of Facility Ambrose Funeral Home of Lansdowne Freberg loa 2719 Hammonds Ferry RD. Baltimore MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical metastasis Immediate Cause (Final with months Concer disaasa or condition rasulting in daath) Examiner Dua to (or as a consequenca of) Examiner Attending Physician: The lew requires that the death certificate be executed pue Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Diseasa or Injury that initiated events rasulting in death) Last Dua to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): ate has been signed by the attending p pege 2 should be detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yas 20 No 1 Yas 2 No within 24 hours after death. To the Funeral Director: After this certificate funeral director, Be 25. Was casa refarred to medical axaminar? 26. Placa of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) Medicai Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yas 2 No invastigation 2 Accident the 6 Could not be datamined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 ☐ Homicida 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) \$ 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier MD October 10, 2000

State Registrar

DHMH 16 Rev 6/95

George

George Saunders

Hospita

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

M.D.,

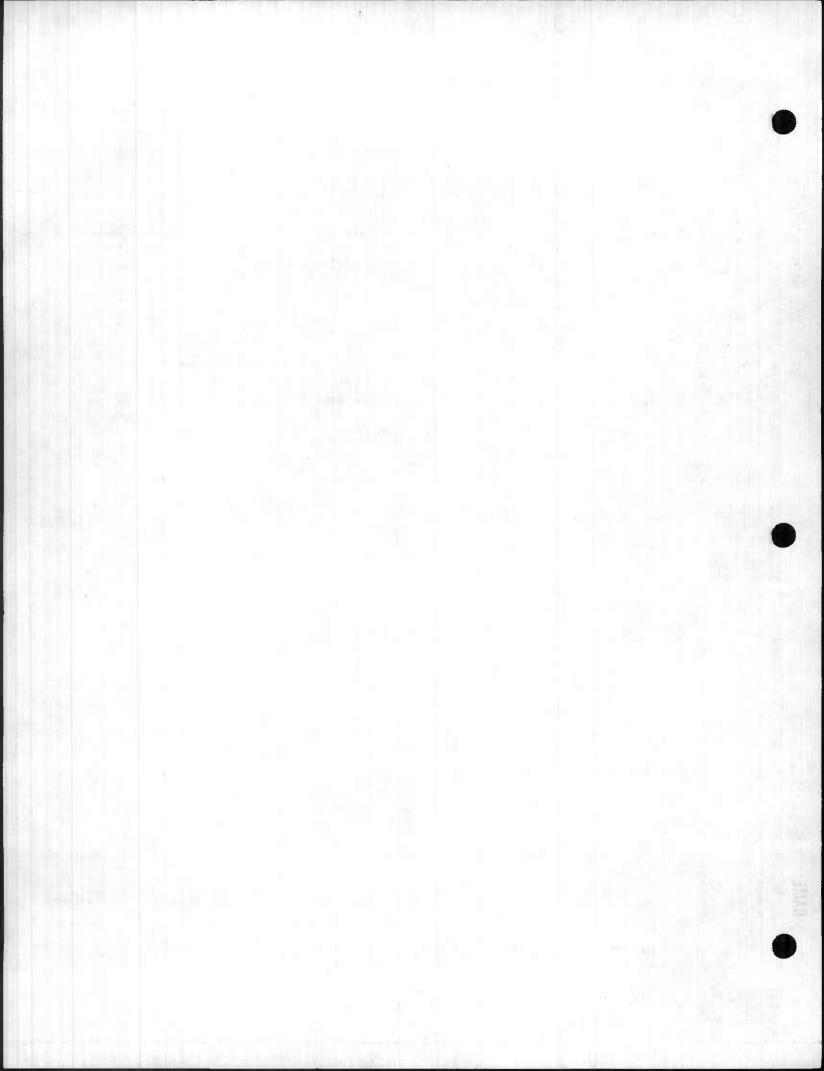
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31. Data filed (Month, Day, Year)...

st. Agnes

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene 0 32179

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her death in the same 23 siner must Funeral	11. Marital Status	12. Was Decede Armed Force	ent Ever in U,	S. 13. \	Was Dece	edent of H	lispenic Origin, Mexican	gin? (Sp	ecify Yes or Rican, etc.)	No-		e - Americ		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#7& Certificate of Death AMEND#8 PER K.B. G788 10-12-2000 JAB 2. Dete of Deeth 1. Decedent's Nama (First, Middla, Last) 3. Time of Death **Physician** SEPTEMBER 2 stone 2000 3:45 p.m. /Medical 4e Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE If Undar 24 Hrs. CITY If Under 1 Yeer 5. Social Sacurity Number 9. Birthplaca (Stata or Foreign Country), 7. Aga (In yrs. lest birthday) **Funeral** Months Days M 2DE Yrs Director Usual Rasidence of Decedant AUGUST 30,2000 with the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 items 23a Funeral filed within 72 hours after deeth 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxicen, Puarto Rican, etc.) 14. Bace - American Indien. 11 Marital Status Black, Whita, etc. 1 Never Merried 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 "natural", or Specify þ 3 ☐ Widowed 4 ☐ Divorced lad Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) of Health and Mentel Hygiene. Gary (0-12) College, (3-4or 5+) NIA NA 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Meidan Sumame) Pages 1 and 2 should be nent of Health end Mentel 19b. Mailing Addrass (Straat and Number or Rural F 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Stata
4 Donetion 5 Other (Specify) permit. Pages Department of Important: If it any injury or o 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Batween Onset and Death **Physician** Immediate Causa (Finel disaase or condition resulting in death) /Medical xtreme Prematuri Examiner Physician/Medical Examiner Sequentially list conditions, it any, leading to immadiata ceuse. Enter Underlying Causa (Disaesa or injury that initiated events rasulting in death) Last the ettending physician and hed for use as the burial-tran The law requires that the death certificate be execut Division of Vital Records, P.O. Box 68760, Hemorr ulmonary Dua to (or as a consequence of) signed by the e 23h. Did tohacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yee 2 No 3 Probably 4 Unknown by 24b. Wara eutopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? page 2 ahould Completed certificata hes 2 210 1 ☐ Yes 2 No 1 Tyes or Attending Physician; Be 25. Wes casa rafarred to medicel 26. Placa of Daath (Chack only ona) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yas 2 No 4 Nursing Homa 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Mennar of Death 28d. Dascribe how injury occurred edical Certification: injury at Work? 5 Panding invastigation 1 Natural 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rurel Routa Number, City or Town, State) 6 Could not be 3 Suicida Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 Homleide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end menner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Cartifiar (Check only one)

State Registrar

31. Data filed (Month, Day, Year) 2 2000

29b. Signatura end title of certifier

Northina 32. Registrar's Signature

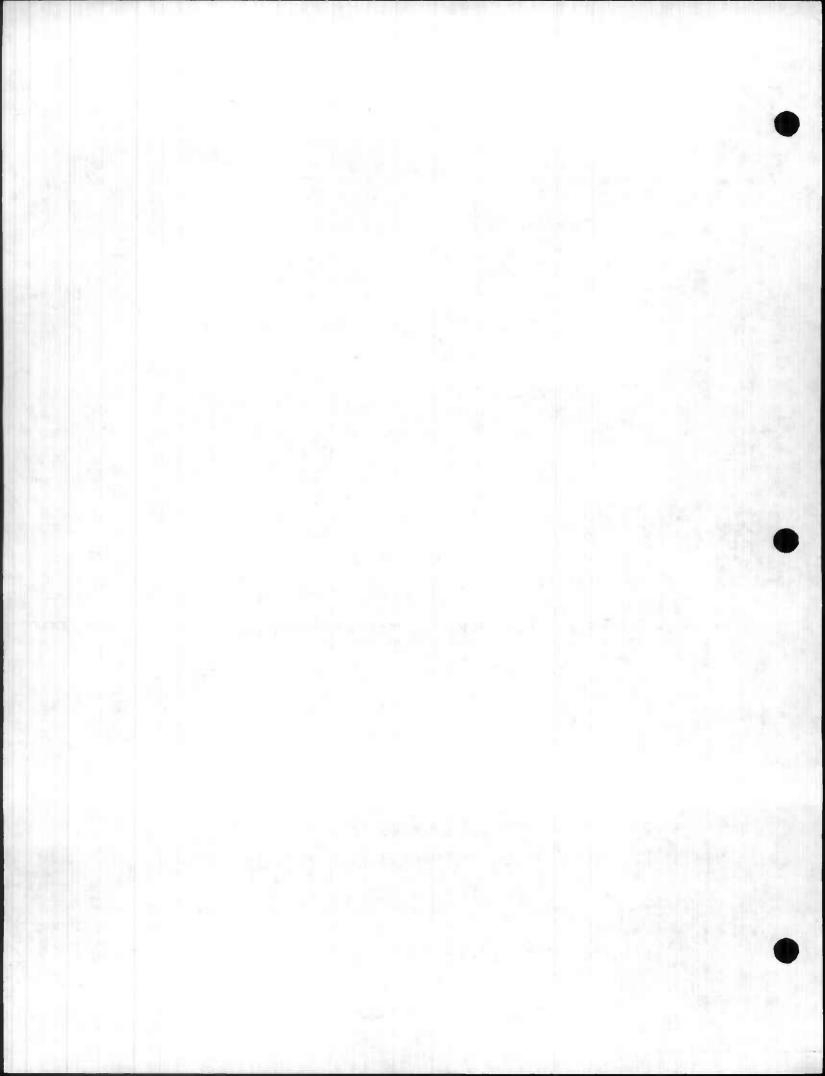
30. Nama end addrass of person who complated cause of death (Itam 23a) (Type, Print)

North Wolfe Street Baltimore MD

29c. Licanse number

29d. Data signed (Month, Day, Year)

To the P



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #8 PER FH G788 10/12/00 AH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey LAZAB2 SONTAG 5:15 PM OCTOBER,9 00 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE 7. Age (In yrs. last birthday) | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth1/14/1912 9. Birthplece (State or Foreign (Month, Day, Vear) 1**X**M 2□ F 220-64-7871 88 POLAND Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ¥ Yes 2 □ No BALTTMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6905 FIELDCREST ROAD 21215 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Merried 2 Merried WHITE 1 Yes 2 No Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) BARBER TONSORIAL 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SZARLOTTY SOLOMON SONTAG RISCHELES 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Retetionship (Type, Print) MAREK SONTAG / SON 5132 WAGON SHED CIRCLE - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stata 20a. Method ol Disposition 1 X Burial 2 Cremetion 3 Removel from Stete 10/11/00 4 ☐ Donetion 5 ☐ Other (Specify) HAR SINAI CEMETERY OWINGS MILLS, MD 21. Signature of Fundant Barrice Licensee 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD — PIK 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart lailure. List only one cause on each line. Approximete Intervel Between Onsat and Death tmmedieta Causa (Finat diseese or condition resulting in death) CEREBROVASCULAR ACCIDENT Due to (or as e consequence of) Due to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETES 24b. Were eutopsy findings evaileble prior to completion of cause of death? 24a. Was en autopsy performed? 1☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury et Work?

Physician /Medical Examiner Examiner

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Division of Vital Records,

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Department of Important: If any injury or page.

Physician

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Pert tt. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case referred to medical examiner? 1 Yes 2 No

27. Menner of Death 5 Pending investigation 1 Natural 2 Accident

6 Could not be detarmined 3 ☐ Suicida 4 Homicide

28a. Dete of Injury (Month, Day Year) 28b. Tima of Injury

28e. Place of Injury - At home, Ierm, street, factory, office building, etc. (Specify)

1 ☐ Yas 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

18 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the causa(s) and mannar stated. (Check only one) 29b. Signeture and title of certifier

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and addrass of person who completed causa of death (ttem 23a) (Type, Print) / . S . R A O . T . O .

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OCTODER, 9,00

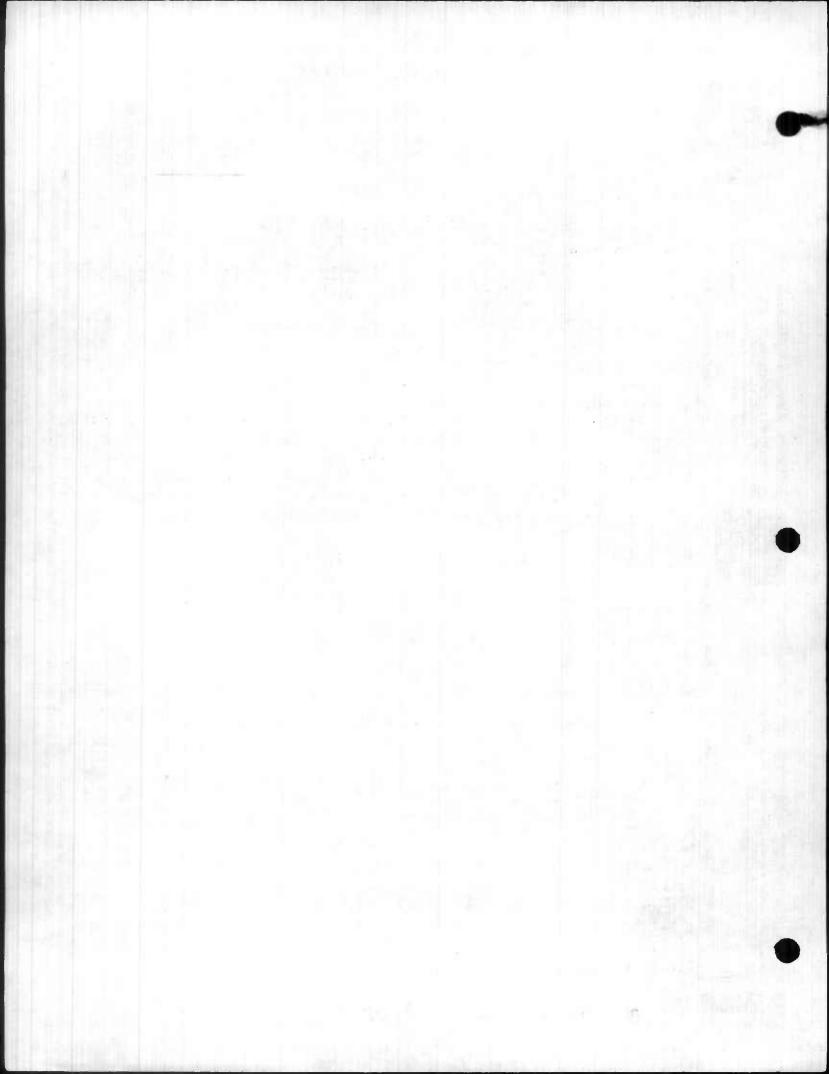
NORTHWEST

31. Dete lited (Month, Day, Year) 1 2 2000

HOSPITAL 32. Registrar's Signeture

CENTER KANDALLSTOWN. oaks

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MARY CATHERINE SEBESTA OCTOBER 9 2000 2:50 am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAL CENTER ROSEDALE BALTIMORE If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth Birthplace (State or Foreign Country) Days Months 1 M ŽOKF Hours 87 195074829 PENNSYLVANIA Usual Residence of Decedent 10b. County 10d. tnside City Limits 10c. City. Town or Location 1 ☐ Yes 2 No BALTIMORE ROSEDALE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 821 ROSEDALE AVENUE 21237 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Black, White, etc. 1 Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced WHITE Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) WILLIS **MYERS** ALICE (HINKLE) 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) PAUL MARTIN SEBESTA (HUSBAND) 821 ROSEDALE AVENUE ROSEDALE, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 Cremetion 3 Removel from Stete 10/11/00 4 Donetion 5 Dother (Specify) GARDENS OF FAITH CEM. BALTIMORE, MD 22. Name and Address of Fecility CVACH/ROSEDALE FUNERAL HOME and Funeral Service Lic 1211 CHESACO AVENUE ROSEDALE. MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth tramediate Cause (Finel disease or condition resulting in death) Cardiac arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (o 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

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To the Hospital or Attending Pi within 24 hours ettar death. To the Funeral Director: After th completely filled in by the funera

The law requires that the death certificate be executed

Box 68760,

Records, P.O.

Division of Vital

Physician

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

It. Pages 1 and 2 should be filed within 72 hours after aftered of Health and Mental Hygiene.

Anti: If Item 27 is marked other than "natural", or ite invry or other treumatic event, the Medical Examina

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Examiner Physician/Medical P Completed 25. Wes case referred to medical 8 1□Yes 2 No

Certification: To 27. Manner of Death

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1 Netural
2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

26. Place of Deeth (Check only one)

Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 28c. tnjury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

id onuse of death (Item 23a) (Type, Print)

Campbell Blud balme 21236 amoriza

31. Date filed (Month, Day, Year) OCT 1 2 2000 State

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Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth Dey **Physician**)ctober 200 /Medical 4c. County of Death 4e Facility Nema (If not institution, give street and number) Examiner nedica TRUCK NIA 0 8. Dete of Birth (Month, Day, Year) Oct. 15,1 If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Months Deys Hours 1 M 2 □ F 84 232-26-8645 Director W.V Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. tnside City Limits 1 ☐ Yes 2√ No Md. Baltimore Dundalk Director "natural", or flems 23s or 28s-f iers. than "natural", or items 23s or 25s-f the Medical Examinar must be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2902 Dunleer Rd. 21222 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

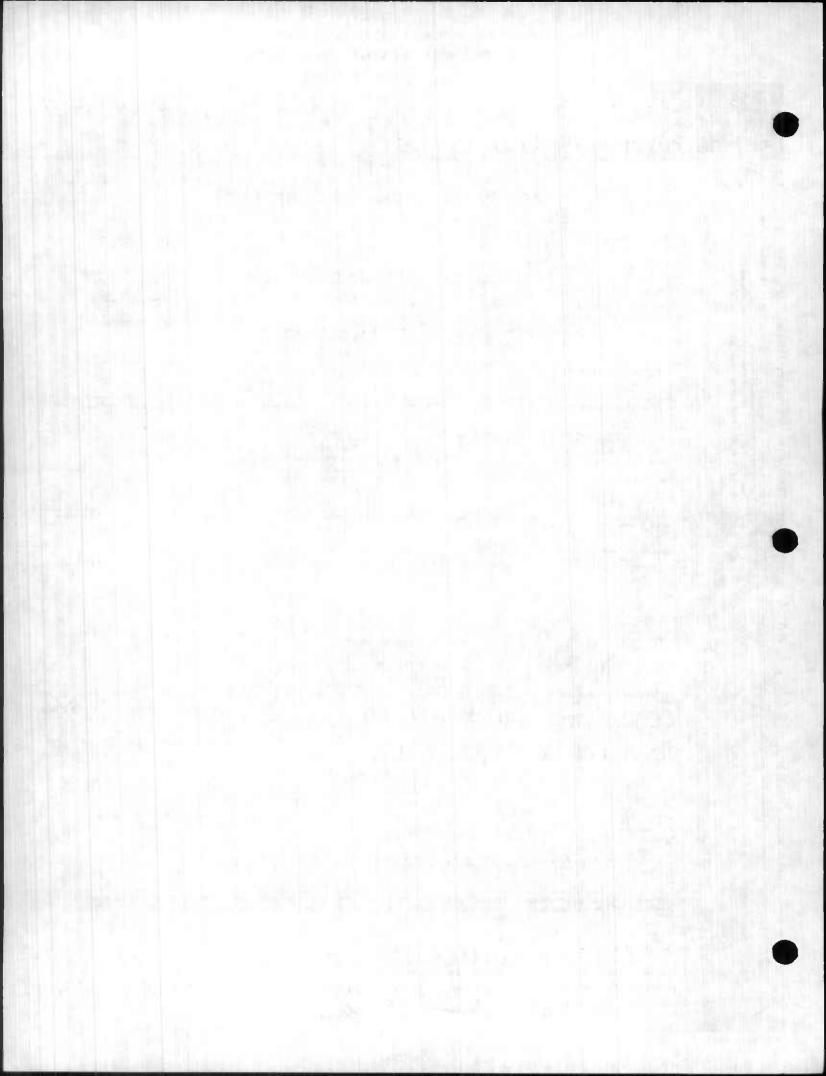
Marries 2 No Hyes, Give Year or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Meritel Stetus filed within 72 hours after 1 Never Married 2 Merried Specify.White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. þ 3℃ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Collega (1-4or 5+) Elementary/Secondary (0-12) 12 yrs. Dentist Self Employed 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Surname) 2 should be t and Mental P is marked Mack Schwing Pauline Burton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Pages 1 and 2 s ment of Health an ant: If Item 27 is 1 Sarah Jane Schwing daughter 2902 Dunleer Rd. Dundalk Md. 21222 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Oct Pate 7 1 ☐ Burial 2 【Cremetion 3 ☐ Removel from State Baltimore Bayview Crematory 2000 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd, 21222 Approximata Intervel Batwean Onset end Deeth Enter the disease, or complications that odused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, or heart failure. List only one cause on each line. **Physician** Immediate Causa (Final diseesa or condition resulting in death) /Medical Examiner Due to (or es a consequence of): Physician/Medical Examiner Sequentially tist conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events Due to (or es e consequence of): use as the buriai-trai The law requires that the death certificate be execu Box 68760. sate has been signed by the attending physician page 2 should be deteched for use as the buria that initieted events resulting in death) Last Due to (or es e consequence of): P.0. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not rasylting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown Division of Vitai Records, Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of daeth? 24a. Wes en eutopsy performed? No No 2 No 1 Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director; Be 25. Was cese referred to medicat examiner? 26. Piece of Deeth (Check only ona) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 2 Inpatient 2 ER/Outpetient 3 DOA Menner of Deat 28b. Time of Certification: 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Plece of Injury - At homa, farm, streat, fectory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) Medical 29a. Certifier end menner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Neme and eddress of person who completed cause of daeth (Item 23a) (Type, Print

DHMH 16 Rev 6/95

State Registrar



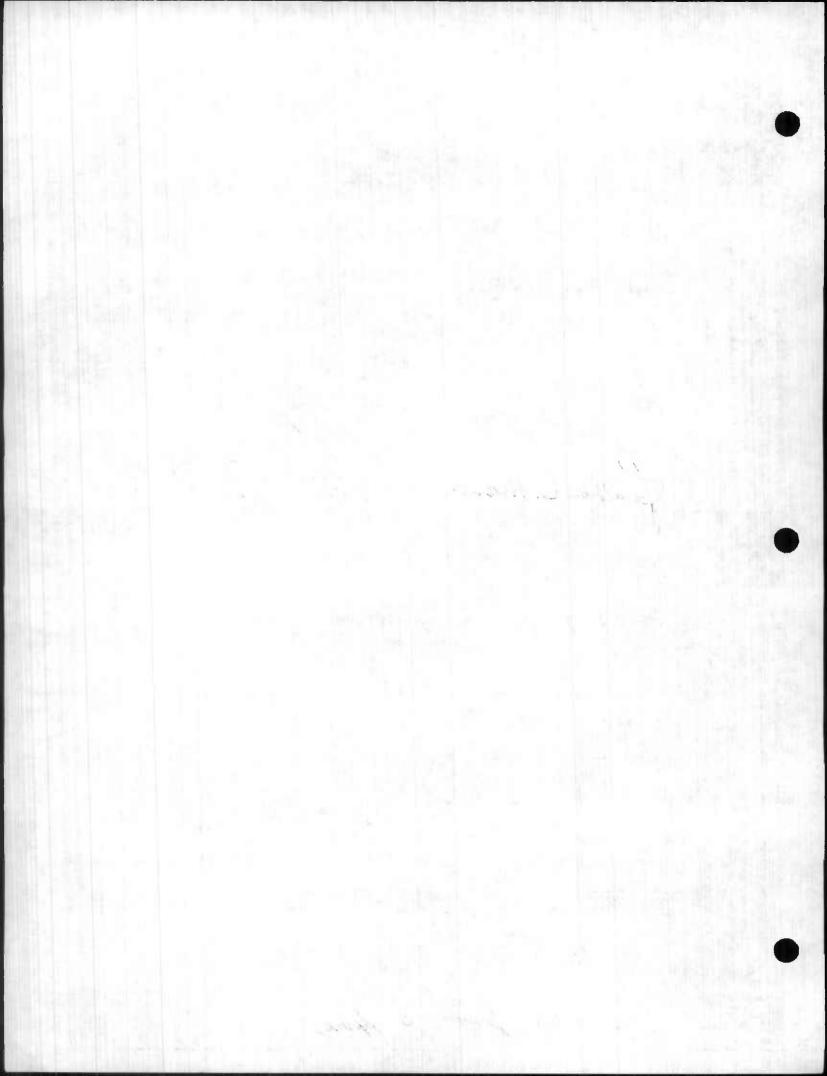
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** CHARLOTTE STREETIE OCTOBER 9, 2000 8:35am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Undar 1 Year | If Undar 24 Hrs. Birthplaca (Stata or Foraign Country)
 ALABAMA 7. Age (In yrs. last birthday) 5. Social Security Number 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours Min 10 M 20 F 9-16-1914 424-28-1252 86 Yrs Director Usual Rasidence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☐ No **Funeral Director** ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 18 ROSEMARIE ST. 21401 USA filed within 72 hours after death 12. Was Dacedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 Yas 2 No If Yas, Giva A Yaar or Datas: 1 ☐ Nevar Married 2 ☑ Married Baltimore, Maryland 21215-0020 "natural", or 1 Yas 2 No Specify Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Specify only highest grada complated) al Hygiene. Elemantary/Secondary (0-12) Collega (1-4or 5+) NURSE HEALTHCARE 18. Mothar's Nama (First, Middla, Maidan Sumama) UNKNOWN 17. Fathar's Nama (First, Middla, Last) permit. Pegas 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked other any injury or other traumatic event PADE. Be BROOKS PERDUE 2 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) VIRGINIA WALLACE (DAUGHTER) 18 ROSEMARIE ST. ANNAPOLIS, MARYLAND 21401 20b. Place of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 □Ramoval from Stata 10-14-2000 LAUREL, MARYLAND MARYLAND NATIONAL } □ Othar (Specify) 4 Donation 22. Nama and Addrass of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND Entar tha disaasa, or complications that ceused tha daath. Do not antar tha moda of dying, such as cerdiac or raspiratory arrast, or haart failura. List only ona causa on aach lina. Approximata Intarval Batween Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical reveronin Examiner Dua to (or as a consequence of) Physician/Medical Examiner The lew requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Disaase or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of) 68760 signed by the attanding physician Due to (or as a consequence of) as the Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to Completed peen completion of cause of death? this certificate has 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: after death. Be 25. Was case referred to medical 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yas 2 40 1 Depatiant 2 ER/Outpatient 3 DOA Medical Certification: To 28c. Injury at Work? 28d. Dascribe how injury occurred 27. Mannar of Death Director: After t 5 Panding invastigation 1 Matural 1 Yes 2 No 2 Accidant 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 Homicida To the Hospital within 24 hours a To the Funeral C completely filled 29a Cartifiar Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29b. Signature and title of certify 29c. Licansa number 32036 10/09/1010 30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print) Doub Drive Charter on 2/6/9 210913. Dran 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

DHMH 16 Rev 6/95

State Registrar

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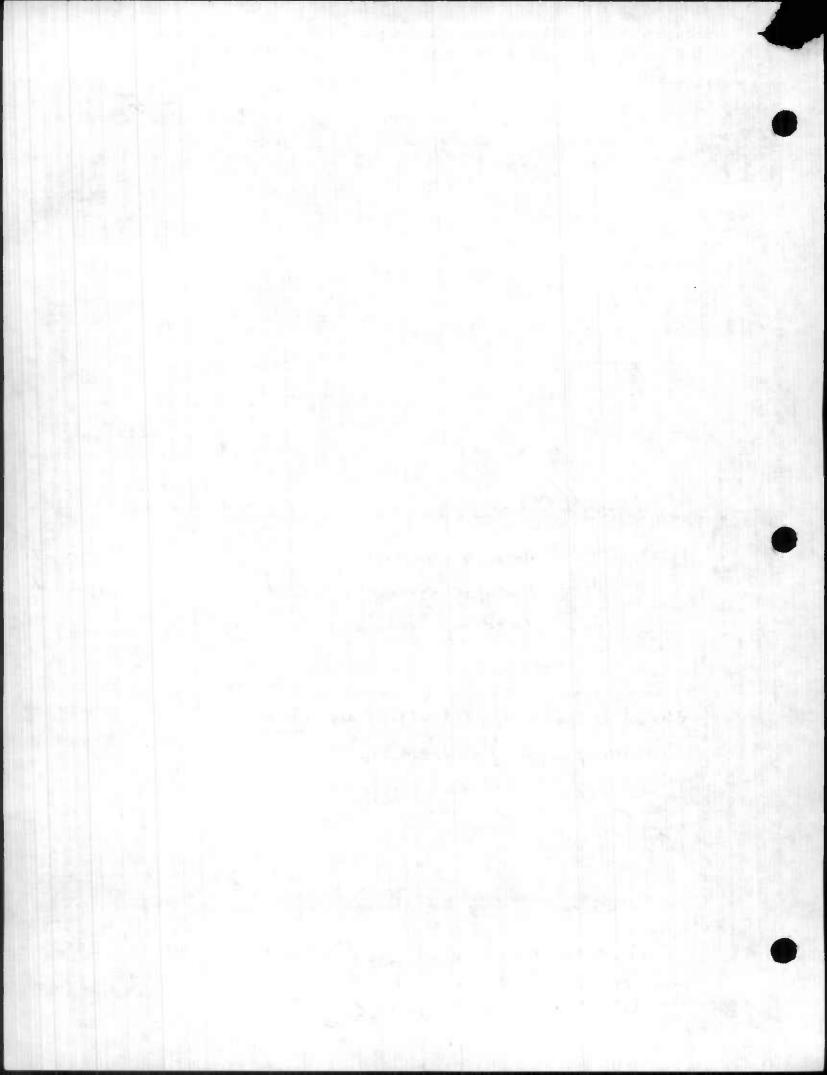
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** Lien Ngoc Tang October 8, 2000 13:10 /Medical 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Deaton Specialty Hospital and Home Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Feb. 3, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1□ M 2♥ F Hours 75 Yrs. 217-11-9289 China Director Usuet Residence of Decedent 10a. Slele 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be nothled at 1 ☐ Yes 2 ☒ No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8526 Pine Run Court 21043 China Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Bleck, White, etc. Dermit. Pages 1 and 2 should be filed within 72 hours after Bepartment of Health and Mental Hygiene. Introcrant: If lem 27 is marked other than "naturel", or the any Injury or other traumatic event, in a second 1 ☐ Yes 2♥ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specity: Specify: Asian by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Ung Tang Muoi Giang 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3350 Hollow Court, Ellicott City, Maryland 21043 Thanh Van Loi / Son 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Oct. 8, Ellicott City, Maryland important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) St. Johns Cemetery 2000 22. Name end Address of Facility Witzke Funeral Home, Inc. 5555 Twin Knolls Road, Columbia, Maryland 21045 ins that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, and on each line. Approximate Interval Between Onset and Death Physician Immediete Ceuse (Finel diseese or condition resulting in deeth) /Medical a. An oxic encephedo portry
Due to (or as a consequence of): Examiner Physician/Medical Examiner Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Box 68760. (ardiae Due to (or es e consequence of): resulting in death) Last P.O. Pert It. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown failure, dialysis depone Be Completed by Records, 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en autopsy 1 ☐ Yes 20 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medicat 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Deeth Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury et Work? Hospital or Attending I 24 hours after death. 1 Natural 5 Pending investigation 1 Yes 2 No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 \ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) and manner stated. 29e. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier oct, 12th, 2000 034974 combita MO 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print), #224, col would a, MD 21045

Registrar

31. Dete filed OCT Day. Zar 2000

32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene

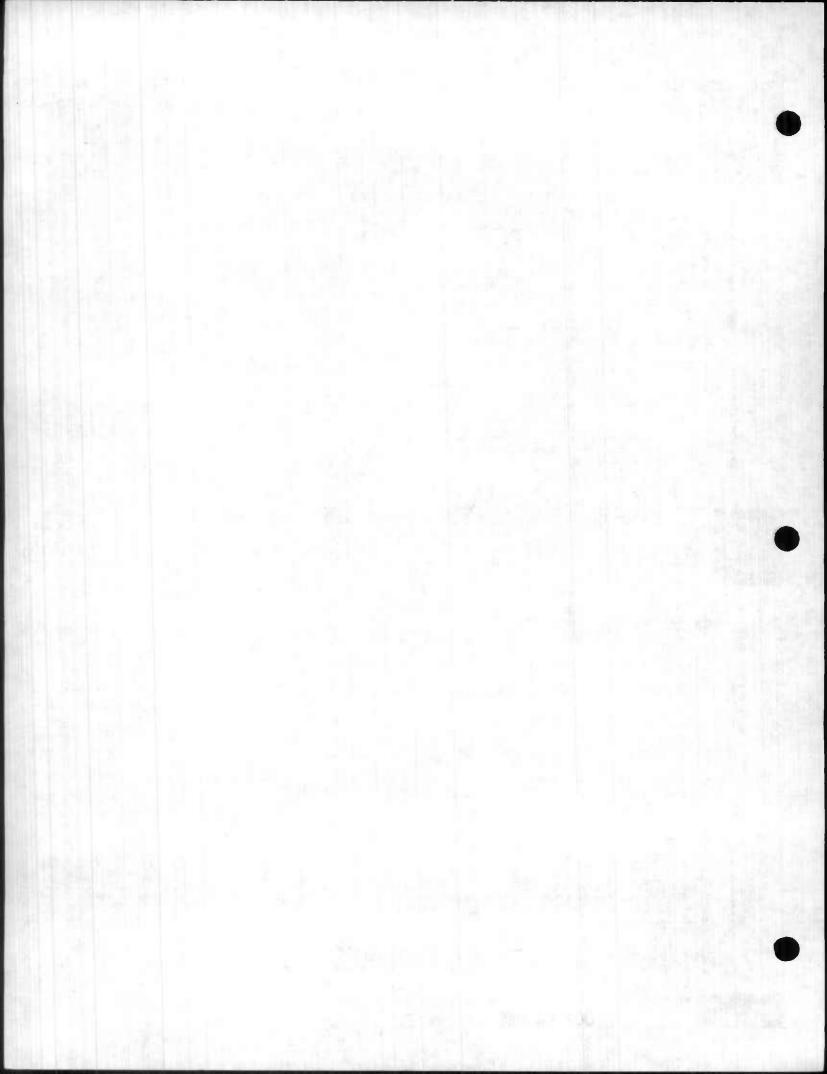
Certificate of Death

Reg. No.

	1. Decedent's Name (First, Middle, Last)	2. Data o				
Physician	Anna Rosemary Taylor	OMonth	ober 11 2000 50Am			
/Medica Examine	to Facility blome (If not institution, give attend and aventural	4b. City, Town, or Location of D	Death 4c. County of Death			
	18 Archwood Ave.	Glen Burnie	Anne Arundel			
Funeral Director	5. Social Security Number 6. Sax 1 M 2 F 60 Yrs. last birthday) Months	Yaar If Under 24 Hrs. 8. Date of (Month) Days Hours Min. May	9. Birthplaca (Stata or Foreign Country) 24, 1940 West Virginia			
2	Usual Residence of Decedent					
death with the Maryland ms 23s or 28s-f show	10a. State 10b. County 10c. City, Town or Location Gle	n Burnie	10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
or 288-f	Maryland Anne Arundel Gle 10e. Street and Number 10f. Zip 0	Code	10g. Citizen of What Country?			
23a c	18 Archwood Ave.	21061	United States			
O # ## !	18 Archwood Ave. 11. Marital Status 1 Nevar Married 2 Married 1 Nevar Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever In U.S. Armed Forcas? 1 Yes, Sive A 1 Yes, Sive A 1 Yes Control of the state of	ont of Hispanic Origin? (Specify Yes of fy Cuban, Maxican, Puerto Rican, etc No Specify:	or No- 14. Race - American Indian, Black, White, etc. Specify: White			
5-00 72 hou		Occupation	16b. Kind of Business/Industry			
21215-002(d within 72 hours e giene. rr than "naturel", o	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 16a. Decedent's Usual (Giva kind of work life. DO NOT use Secretary) Secretary	t dona during most of working o retired)	Education			
	17. Fathar's Name (First, Middla, Last)	18. Mother's Name (First, Mi				
ylan ould be Mental Mental arked c	Unknown	Nora Slaugh	ter			
Maryland nd 2 should be file lith and Mental Hy 27 is marked othe r treumatic event	19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) vood Ave. Glen Burnie, MD. 21061				
altimore, mit. Pages ta pertiment of Hes portent: if Nem y Injury or othe	20a. Method of Disposition 1	har placa)	20c. Location - City or Town, State OO Catonsville, MD			
Balt permit. Depend Importa	21. Signature of Funeral Service Licensee 22. Name and 1328 S Arbutu	Addrass of Fscility Ambros ulphur Spring Rd. s, MD. 21227	se Funeral Home, Inc.			
Contilicate be executed with the properties of t	Immediata Cause (Final disaase or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of):	is Mening breast	gitis I mostly cancer 3 months			
W = 9 2	Pert II. Other significant conditions contributing to death but not resulting in the underlying ca	use given in Pert I. 23b.	Did tobacco use contribute to the cause of death?			
P.O. that the sed by the detache			1 Vss 2 No 3 Probably 4 Unknown			
of Vital Records, P.O. Be Physician: The law requires that the deeth this certificate has been signed by the atternal director, page 2 should be detached for	Pert II. Other significant conditions contributing to death but not resulting in the underlying ca	248.	Was an autopsy performed? 24b. Were autopsy tindings available prior to complation of cause of deeth?			
I Re lav			1 Yes 2 No			
Vital Respector. The indirector, page	25. Was case reterred to medical examiner?	26. Place of Deeth (Check of	only one)			
Of Vita Physician: this certific	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO/	1	Residence 6 Other (Specify)			
After fune		Bc. Injury at Work? 1 Yes 2 No	ribe how injury occurred			
Division or Attending after death. Director: After J in by the fune	3 Suicide 4 Homicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, building, etc. (Specify)		ion (Street and Number or Rural Routa Number, or Town, State)			
Division To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	27. Manner of Death 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Class of Injury M 28c. Placa of Injury - At home, farm, street, factory, building, etc. (Specify) 29a. Certifier (Check only one) 29a. Certifying Physician: To the best of examinetion and/or investigation, and menner steted.					
To the complex		D 3904	29d. Data signed (Month, Day, Year) October 11, 2000			
6	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOS NIMAGADDA 30015, Ho	unover Hospis	et Baltimox MD			
State		-				
Registra	OCT 12 2000 peners 1	Sparts	-			
DHMH 16 Rev 6/95		9.4				

ORIGINAL

Anna Rosemary Taylor

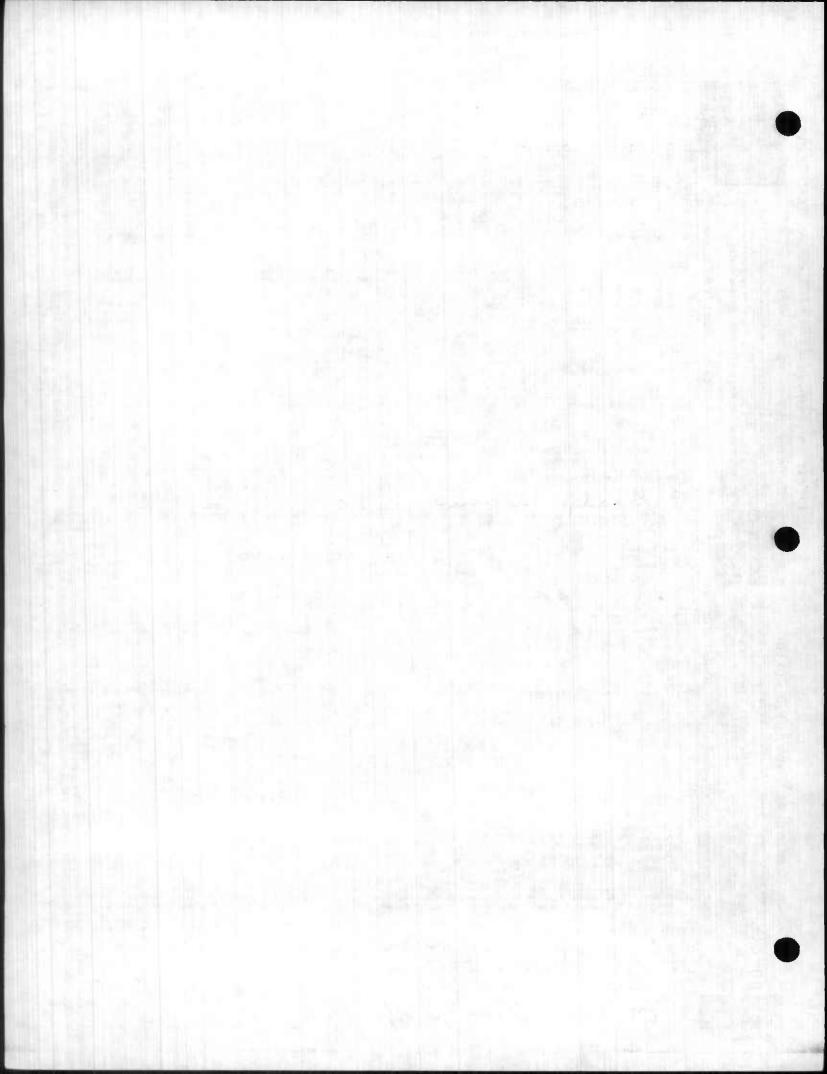


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2 60 7			State of Ma			tificate o			Reg. No.	0 4	1 0 1
Physicia	an	Decedent's Name (First, Middle, Last)						2. Date of De Month	Dev	Year	3. Time of Death
/Medic		Ronald R.	Thomps	son			4h Cihi Taum ai	Oct -		000	8:50pm
Examin	ner	4a Fecility Name (If not institution, give s	reet and number)								
		Gilchrist Hosp 5. Social Security Number 6. Sex	ice Car	e (In yrs. last bi	irthday)	If Under 1 Yes	Baltin		th N		lace (State or Foreign
Funeral Director				66	Yrs.	Months Day	s Hours Mir	8. Date of Bir (Month, De 08-2	3-34	Count	MD
B .		10a. Stete 10b. County		10c. City, Tov	vn or Loc	ation			Od. Inside City Limits		
Men H	tor	MD NA		Balt	imor	re					1 X Yes 2 □ No
4 18 P	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	het Count	iry?
23 with		2409 Callow Ave	nue			21	217		USA		
after death with the Maryla are death with the Maryla or thems 23s or 25s-f sho uniner must be notified at	Funeral	11. Marital Status 1 1 Never Married 2 Married 1	2. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give			/as Decedent of Yes, specify Co	Hispanic Origin? (uban, Mexican, Pue o Specify:	Specify Yes or No rto Ricen, etc.)		, White, e	
E E	d by	3 Widowed 4 Divorced	Year or Dates:							Blac	
72 math	Completed	15. Decedent's Educ (Specify only highest grade	etion com <i>pleted)</i>	168	(Give k	ent's Usual Occ and of work do	upation se during most of wi red)	orking	16b. Kind of Bu		
Paris in A	du	Elementary/Secondary (0-12)	College (1-4or 5+	-)		affuer	rea)		Baltim		_
HEER'S		17. Father's Name (First, Middle, Last)			0	211401	18. Mother's Ne	eme (First, Middle	Water Maiden Sumeme		
d be d be d be d be d be	To Be	Raymond	Thom	ngon			Geral	dine	Minor		
method was	Pm	t9a. Informant's Name/Relationship (Typ		er, City or Town,		Code) 21217					
27 tra		Gladys L. Th	ompson	2	409	Callo	w Avenue	e Balti	more, M	ary.	
off Had		20a. Method of Disposition		20b. Place o	of Dispos	sition (Neme of setory or other p	lace)	Date	20c. Location -	City or To	wn, State
Pages national ny or o		1 ☐ Buriel 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State				Pk. Cem	10-13	-2000 A	rbut	tus, MD
emit. Apartm mporta ny inju		21. Signature of Funeral Service License	Э		22.	Name end Add		altimor	e,Maryl	and	21202
. 40240		A Lady	wan	Con			rch FH	1101 E.	North	Ave	nue
		23a. Pert1. Enter the disease, or complice shock, or heart failure. List only one	ations thet caused to e cause on each line	the death. Do	not ente	r the mode of o	ying, such as cardi	ac or respiratory	orrest,		Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition Drosfate CANCER									Onset and Death Q YEARS
Examiner		Due to (or es e consequence of):									
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cate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or rigury c.								1	
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	edical	resulting in death) Lest		ue to (or as a	consequ	rence or):					
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ie death certif	ICIa	Part II. Other significant conditions cont	ributing to death but	t not resulting	in the un	deriving ceuse	given in Pert I.	23b. Did	tobacco usa con	tributs to	the cause of death?
ires that the death cert signed by the attendin id be detached for use	y Physician/M	Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.							Y88 2 No	3 Prot	
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Physician: this certific ral director,	o Be	examiner?	ospital:	nt 2 ER/O	outpation	3 DOA	Whor:	Home 5□ Res		er (Specifi	w Hassida
ding Phy h. After this funeral o		27. Menner of Deeth 1 Netural 5 Pending 2 Accident Investigation	28e. Date of Injury (Month, Day	/ 28b.	Time of Injury	28c. Ir			how injury occurr		"ty orpice
To the Hospital or Attending Physician: The Lawithing A hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, 1 (Specify)	larm, stre	eet, factory, office	> 8	28f. Location City or To	(Street end Number own, State)	er or Rura	I Route Number,
Hospita 24 hours Funeral stely fille	edical C	29e. Certifier (Check only one) 1 Certifying Physical Certifying Physical Examination (Check only one)		examination a							
o the	Me	29c. License number 29d. Date signed (Month, Day, Year)									
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Ost,	1	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) W. A. R. (by GBMC 6701 N. Charles St. Balto, in d									
011	10	31. Date filed (Month, Day, Year)	22. Registra	r's Signature	01	1		0 01 /	7700	21	20×
Sta Registr		OCT 1 9 2000	home	1 19		land.	/			-	

10.9.3000

HOMPSON, RONALD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time for the October 5, 2000 Year DORIS E. VOLKMAN 2:25 M 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home Rockville If Under 24 Hrs. Montgomery 9. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 1□M 2X0 F Months Deys Hours Min. Yrs. 83 220-22-8911 Aug 8, 1917 MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9701 Veirs Drive 20850 USA 11. Marital Status Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Yes 22 No 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 N Widowed 4 Divorced Year or Dates: white 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Hoefel Carrie J. Lindeman 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) National Lutheran Home 9701 Veirs Drive Rockville, MD 20850 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Somature of Europe Service Scenese Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23 . Part1. Enter the linease or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in deeth) neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Lest palmonary thrombo emboli poument Part It. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy im balance 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other:

Physiclan /Medical Examiner

permit. Page Department of Important: If any Injury or

Physician

/Medical

Examiner

Funeral

Director

ral', or items 23a or 28a-f show Examiner must be notified at

Pages 1 end 2 should be filed within 72 hours aftar nent of Health and Mantal Hygiane. net If Itam 27 is marked other than "natural; or ite ury or other traumatic event, tra Modical Exprise.

3altimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be 2 unk

MD

the Maryland

death with

The law requires that the death certificate be axecuted the buriel-trensit P.O. Box 68760, for use as signed by the Division of Vital Records, 99 certificate has nepital or Attending Physician: Theoris after death.
Inerel Director: After this certificate y filled in by the funeral director, ps

Physiclan/Medical Examiner þ Completed Be Certification: To

Medicai

Registrar

29b. Signature and title of certifie

1□ Yes 2⊟No

27. Menner of Death

2 Accident 3 Suicide

4 Homicide

29a. Certifier

1 Natural

Dete of Injury (Month, Day Year)

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year)

2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Nursing Home 5 ☐ Residenca 8 ☐ Other (Specify)

Dr. Germantown

28d. Describe how injury occurred

Name and address of person who completed cause of death (Item 23a) (Type, Print) Amaranth 19500

MP ler 31. Date filed (Month, Day, Year)

DCT 12 2000

5 Pending Investigation

6 Could not be determined

32. Registrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

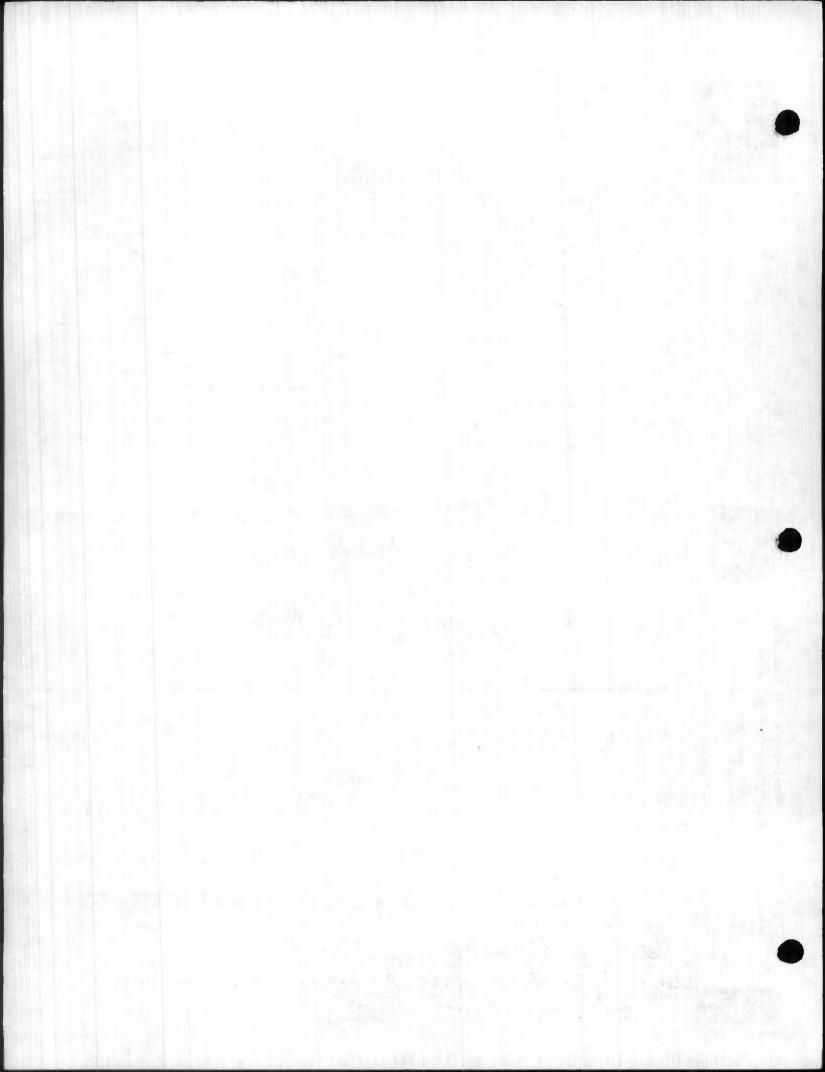
28b. Time of

28c. Injury at Work?

1 Tyes 2 TNc

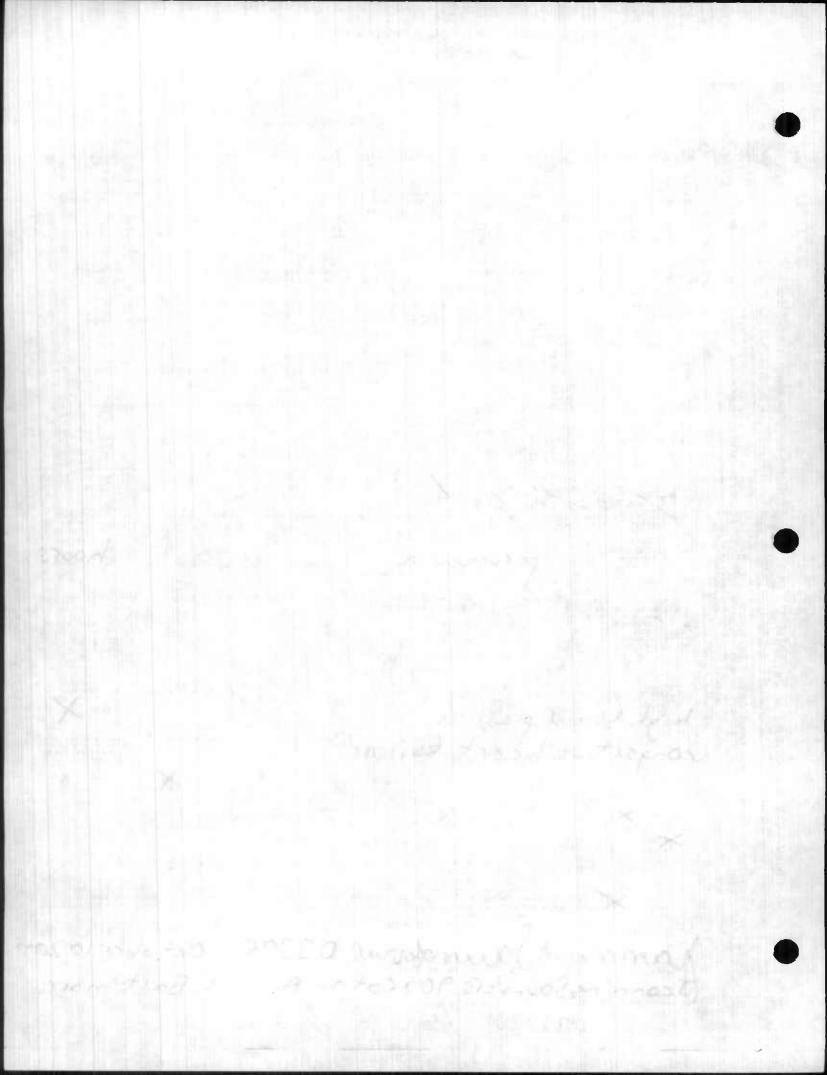
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To the Hospital o within 24 hours aff To the Funeral DI complately filled in

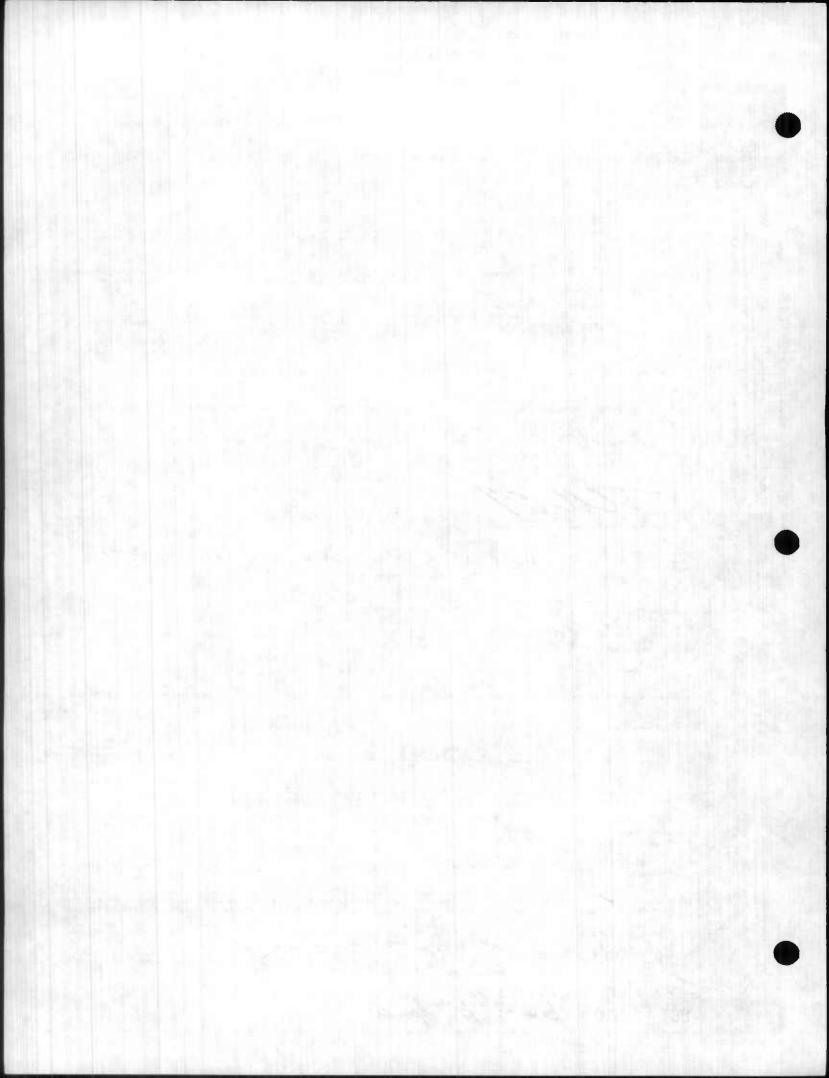


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificate of i	Death	Reg	. No. UU	32189
	Dharatatan	Decedent's Name (First, Middle, Last)	ATA			2. Data of Death Month	Day Y	3. Time of Death
0	Physician /Medical	Mary Vander	eedt			Octo bee	10,2	
	Examiner	4a Facility Name (If not Institution, give street and nu	mber)	4	lb. City, Town, or L	ocation of Death	4c. County of	Death
		St. Agnes Hospital			Baltimo		n/a	
	Funeral	5. Social Security Number 6. Sax	7. Age (In yrs. last birthday) 96 Yrs.	Months Days	If Undar 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, 1)). Birthplace (State or Foreign Country)
L	Director	Usual Residence of Decedent	96			Aug. 31	1904	Ireland
	Bu Bu	10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	r 28e-f sh notified inector	Md. Anne Arundel (Co. Annap	olis				1 ☐ Yes 2√ No
	or 28a-fr	10e. Street and Number		10f. Zip Code		100	g. Citizen of Wh	at Country?
		1159 Neptune Place			21401		USA	
	ther death in the the the the the the the the the the	1t, Marital Status 12. Was Dec Armed Fo	edent Evar in U,S. 13. prcas?	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
50	0 5 5	1 Never Married 2 Married 1 Yas	2 No	1□ Yes 2□No	Specify:		Specify:	- 4-2-4
00	hours MEra al Era ad by	3 X Widowed 4 □ Divorced Year or D		dent's Usuel Occup	ation	14	6b. Kind of Busi	white
5	ed within 72 ho ygiene. wer then "neture it, the Medical. Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done	during most of work	ring	DD. KING OF BUSI	nosamousny
212	the lens	Elementary/Secondary (0-12) College (1-4or 5+)	ousewife			Home Ow	ner
P	tal Hyg d other event, Be C	17. Father's Name (First, Middle, Last)		Jusewille	18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	
lar	Menta Menta stices of to B	Anthony O'Donnell			Beatrice	2		unknown
Maryland 21215-0020	and N	19a. Informant's Name/Reletionship (Type, Print)	19b. Maili	ng Address (Street	and Number or Rui	al Route Number,	City or Town, Si	tete, Zip Code)
2	and and a	Arthur J. Van Dereedt (S		9 Neptune	Place, A	Annapolis	, Md. 2	1401
ore	T then	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from	20b. Place of Dispo cemetery, cre	osition (Name of matory or othar plac				ity or Town, State
altimore	Pag uny cury	4 Donation 5 Other (Specify)	Green Mo	unt Cemet	ery 10/1	2/2000	Baltimo	re, Md.
Salt	appart ny lay	21. Signature of Funaral Service Licensee		2. Name and Addre	D-12-2-	Funoral	Homo D	7
	20239	23a Part1. Enter the disease, or complications that a shock, or heart failure. List only one cause on a	min	3204 Mou	ntain Roa	d. Pasad	enaMd	21122
	Physician /Medical Examiner	Immediate Cause (Final	Due to (or as a conse	quence of):				Onset and Death
09,		Cause Enter Underlying Cause [Disease or Injury that initiated events		-2\				1
68760	licate be physicia to the bu	resulting in death) Last	Dua to (or as a consec	quance ot):				
Вох	modern uses n/M	d						
	death or s attend d for us dicisry	Part II. Other eignificant conditions contributing to d	eath but not resulting in the u	Inderiving cause giv	ren in Part I.	23b. Did tob	acco use conti	ribute to the cause of death?
P.0	by the darked	1 - 1 11 11 0	10			1 Tye	8 2□ No 3	Probably Unknown
	signed d be de d by B	righ graced bis	33010					
Records	The law requires that the death ce rate has been signed by the attend page 2 should be detached for usa Completed by Physician/	anaretiis !	art tai	1.10		24a. Was an perform		24b. Were autopsy findings available prior to completion of cause
90	has by pe 2 st mple	LONG CO GOO RC	24 / 2011	COTO				of death?
=	The Land	9				1 🗆 Yes	No	1 ☐ Yas 💥 No
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Division of	After After Itom	Naturel 5 Pending (Mor.	of Injury th, Day Year) 28b. Time of Injury	Wor	k? Yes 2□No	200. 0 0001100 1101	in injury occurre	
isi	Atten r deat sctor: by the	3 Suicide 6 Could not be 28e. Plece	of Injury - At home, ferm, st					or Rural Route Number,
Š	and of the	4 Homicide build	ing, etc. (Specify)		7 LS	City or Town,	State)	
	hours a meral D y filled yalled	29a. Certifying Physician: To the						
	To the Mospital or Attending P within 24 hours after death. To the Furieral Director, After to completely filled in by the funeral Medical Certification:	(Check only 2 Medical Examiner: On the band man	asis of examination and/or in ner stated.	ivestigation, in my o	pinion, deeth occur	red at the time, da	te and place, ar	id due to the cause(s)
	Within To the comple	29b. Signature and title of certifier		29c. Licans	a number	29	d. Data signed	(Month, Day, Year)
		a samure 10	Linder	D Com	330	6/0	etal	oes (0,2000
	n	a). Name and address of person who completed cau	se of death (Item 23a) (Type	Print)	_		C 11	
_	1	Dranning Joyna	255 700	ato	n Huc	nuc	Bal	Cimorc
	State	di. Date filed (Month, Day, Year) 32. F	Registrar's Signature	1	1 3			/ / = 101
	Registrar	OCT 1 2 208	1) Deper	fred	Boards			



	Decedent's Neme (First, Middle, Last)	Certifica	ate of	Death	2. Dete of De	Reg. No.	3. Time of Death					
Physician	Omar B. Wesse				7.1	Month	Dey	Yeer					
/Medical Examiner	4a Facility Neme (ff not institution, give				4b. City, Town, or Lo								
LAGITITICI	4711 Forge Road				Perry He	all	Bal	timore					
Funeral Director	210-14-0002	7. Age (fn yrs. I	last birthdey) If Un Yrs. Month	der 1 Year ns Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bird (Month, De May 23,	th y, Year) 1924	9. Birthplace (State or Foreig Country) Maryland					
2 2	Usuel Residence of Decedent 10a. Stete 10b. County	10c. City	, Town or Location					10d. Inside City Limits					
To to	Maryland Baltimor	.e	Pe	rry Ho	all			1 ☐ Yes 2 💢 No					
rec	10e. Street and Number		10f.	Zip Code			10g. Citizen of W	het Country?					
3a o	4711 Forge Road			21	128	100	u.s.	Α.					
Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than *naturef, or Item 23a or 28-4 show any Injury or other traumatic event, the Medical Energiest must be nothed approach. To Be Completed by Funeral Director	11. Merital Status 1 Never Merried 2 Merried 3 X Widowed 4 Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 ¼ Yes 2 ☐ No If Yes, Give Yeer or Detes: WW 【】	1 ☐ Yes	cedent of H pecify Cube 2X No	dispanic Origin? (Spi en, Mexican, Puerto Specify:	spanic Origin? (Specify Yes or Non, Mexican, Puerto Rican, etc.) 14. Race - Amer Black, White Specify: Specify: Specify: 14. Race - Amer Black, White Bla							
ted fat	15. Decedent's Edu (Specify only highest gred	cation	16e. Decedent's U	suel Occup	pation	ina	16b. Kind of Bus						
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marked oth marke over marke even	17. Fether's Neme (First, Middle, Last)	P		17.79	18. Mother's Name			9)					
Mental marked or matic ever	Charles Wesse		T				Brown						
h end le m treum	19e. Informent's Neme/Reletionship (T) Mr. Dennis M. Wes				end Number or Run Road, Bali								
Heelt Pm 2 ther	20e. Method of Disposition	20b. P	lece of Disposition (Verne of		Date		City or Town, Stete					
Department of Heelth Important: If Item 27 is any injury or other tra	1 X Burial 2 ☐ Cremetion 3 ☐ F	Compuel from State	emetery, cremetory of	or other plea				more, Marylane					
ortant njuny	4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licens				ess of Fecility	10/14/	oo bacaa	more, margrara					
Depa Impo	21. Signeture of Furielal Solvide Liberts		Schi	nunek	Funeral ir Rd., B	Home, I	nc.	1236					
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page Corr						10	Yes 22 No	1 ☐ Yes 2 ☐ No					
director, page	25. Wes case referred to medical examiner?				26. Plece of Deet	h (Check only	one)						
After this certific funeral director,	1 Yes 2 No 27. Manner of Death 1 Neturel 5 Pending	Hospitel: 1 ☐ Inpatient 2 ☐ 28a. Dete of Injury (Month, Dey Year)	ER/Outpatient 3 28b. Time of Injury	28c. Injui			dence 6 Othe						
st Director: After the in by the funeral Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At ho building, etc. (Specify	tory, office	28f. Location (City or To		er or Rurel Route Number,							
	29e. Certifler (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
24 hours eff Funeral Di etely filled in dical Cer		and menner steted.		29b. Signature and attend of certifier 29c. License number 29d. Date signed (Month, Dey, Year)									
othe Funeral Di on pletely filled in Medical Cer	(Check only 2 Medical Examione)			29c. Licens	se number		29d. Date signed	(Month, Dey, Year)					
within 24 hours efter death. To the Funeral Director: After the completely filled in by the funeral Medical Certification: 1	(Check only 2 Medical Examione)		2	29c. Licens	se number		29d. Date signed	(Month, Dey, Year)					
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White About all to the Funeral Dir completely filled in	(Check only 2 Medical Examione)	and menner steted.	2	29c. Licens D	31775 FALLS	Ton M	29d. Date signed OCTOBG	(Month, Dey, Year)					



State Registrar

31. Date file

DHMH 16 Rev 6/95

ddress of person who completed cause of death (Item 23e) (Type, Print)

tanes

32 Registrar's Signature

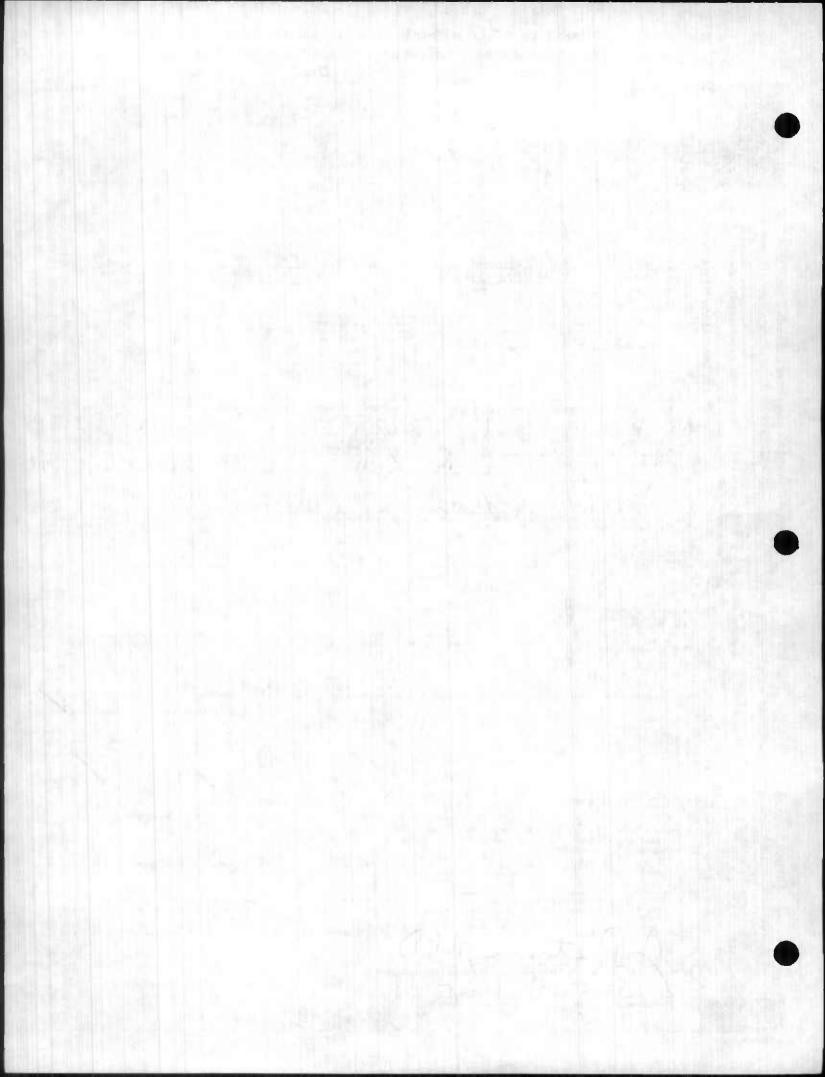
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111 Penn Street, Baltimore, Maryland 21201

SEPTEMBER 29, 2000



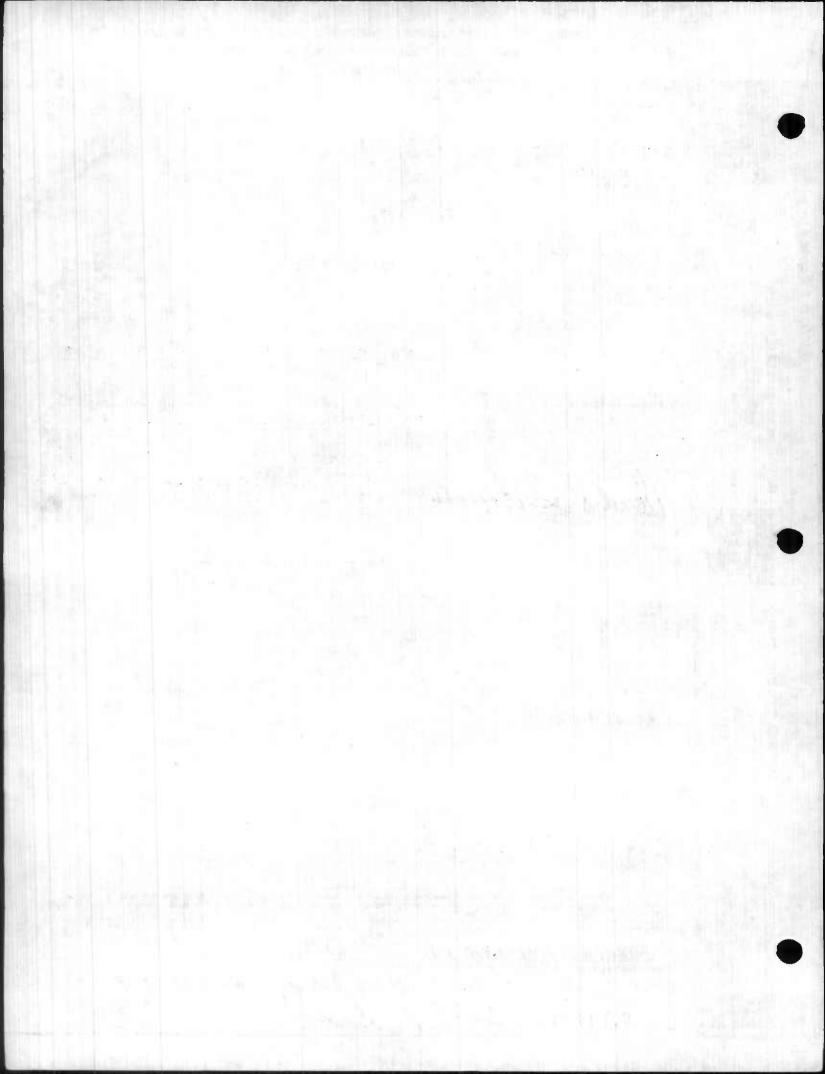
A. Del	Decedent's Name (First, Middle, Last)	State of Maryla		ertificate of			Reg. No.		192	
Physician	Louise	G.	Wil	liams		Month Oct.	06, 200	Year 5	:00am	
/Medical Examiner	4a Facility Neme (If not institution, give s	treet and number)			4b. City, Town, or L	ocation of Deat	h 4c. County	of Death		
Funeral	Genesis Elder C	7. Age (In yr.	s. last birthday				th ey, Year)	NA 9. Birthplece Country)	(State or Foreign	
Director	219-10-8226 Usuel Residence of Decedent	M 2□F 75	Yrs.			09-3	0-25		SC	
Mon	10a. State 10b. County		City, Town or L					10d. lr	sida City Limits	
o Mer si	MD NA	Ва	altimo	ore				1	V Yes 2□No	
vith th	10e. Streat and Number			10f. Zip Code	2		10g. Citizen of V USA	Vhet Country?		
72 hours efter death with the Meryland natural; or items 23e or 28s-f show the Examiner must be notified at sted by Funeral Director	3337 Cliftmont	AVENUE 2. Was Decedent Evar in	US 13	2121		pacify Yas or No		e - Amarican In	dien.	
fer d	1 Never Merried 2 Merried	Armed Forces? 1 ☐ Yes 2X No	0,5.		Hispanic Origin? (Sp ben, Mexican, Puerto	Rican, etc.)	Blac	k, White, etc.		
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end in 27 in 27 in the tr	David G. Eley				nont Ave		ltimore	e, MD.	21213	
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it. Pa	4 Donetion 5 Other (Specify) 21. Signature of Funeral Service License	*		On Fores	non of English					
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	23a/Bart WEnter the disease, or-combin	cations that caused the da	N.		ch FH 1				eroximete	
Physician	shock, or heart feilure. List only on	a cause on each line.						fnte	rvel Between at and Death	
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hysician: his certific il director, To Be (exeminer? 1 ☐ Yes 2 Ø No	ospitel: 1 Inpatient 2	☐ ER/Outpati	ent 3 DOA	ther .		idence 6 □Oth	er (Specify)		
£ £ 2	27. Manner of Deeth 1 ☑ Natural 5 ☐ Pending	28e. Dete of Injury (Month, Day Year)	28b. Time fnjury	W	ork?	28d. Describe	how injury occur	red		
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or At after d Direct in by	4 Homicide determined	Ð		(Street and Numl wn, State)	er or Hural Ho	ule NUMDer,				
Hospital or 24 hours afte Funeral Din Mely filled in Mely filled in	29a. Certifier 1N Certifying Phys	iclan: To the best of my ke	nowledge, des	eth occurred at the	time, dete end plece	and due to the	cause(s) and me	enner as stated		
To the Hospital or At within 24 hours after to the Funeral Direct completely filled in by Medical Certiff	(Check only 2 Medical Examin	er: On the basis of examinend manner steted.	netion end/or	nvastigation, in my	opinion, deeth occu	rred at the time	, dete end place,	end due to the	cause(s)	
Within 2 To the Comple	29b. Signature and title of certifiar			29c. Licer	nsa number		29d. Date signe	d (Month, Day,	Year)	
,0	YMATHA C. 101	MUMAL I	111	05	4518		10/9/2	,		
2	30. Neme end address of person who con	mpleted causa of death (It	em 23a) (Type	e, Print)	1	0.4				
111	MARTHA C. RAMMY	NOO 3007	8. NOI	thern ha	huay ba	Chone	MD2111	4		
State	31. Dete filed (Month, Day, Year)	32. Registrer's Sig	noturo							

DHMH 16 Rev 6/95

State Registrar

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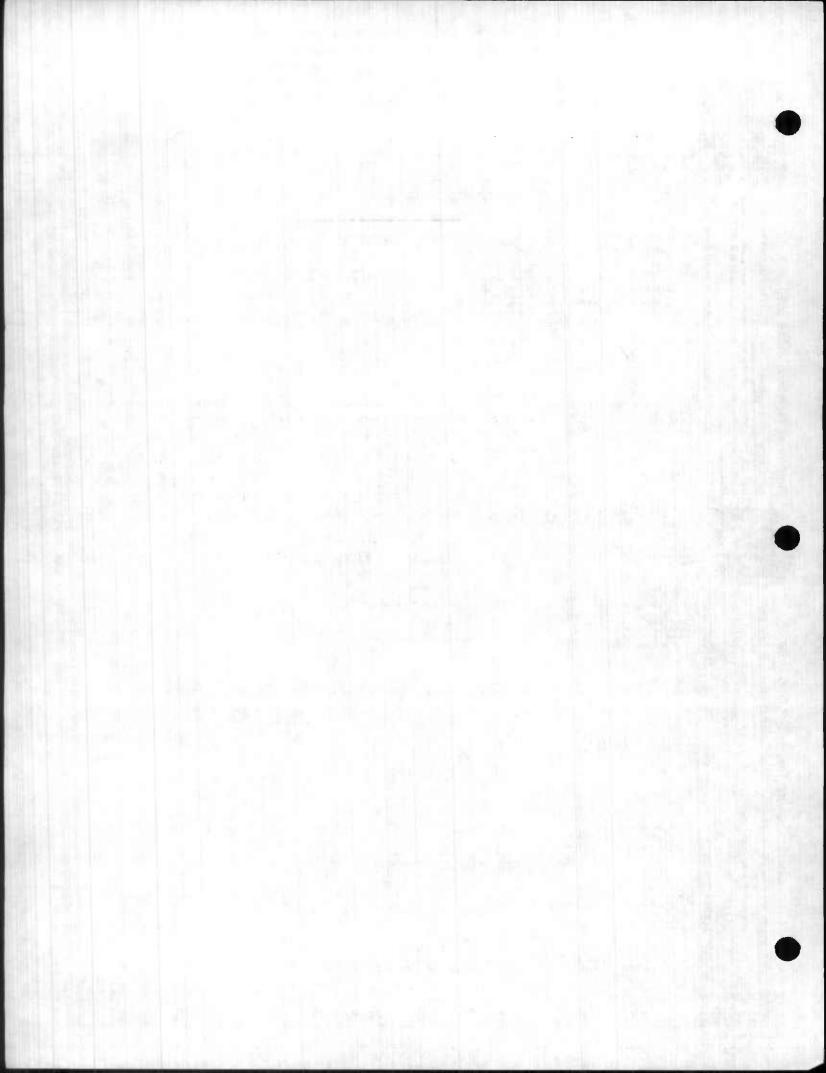
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ORIGINAL



	AMEND ITEM	#10c PER FH	Please I G788 10/12	State of Ma /00 AH			ent of He	alth and I	Mental Hyg		32193	
	Physician /Medical	1. Decedent's Ne	me (First, Middle, La ELEANOR	st)		WEIS	SMAN		2. Dete of Dea Month OCTOBER	Dey Ye	3. Time of Death 2:10 PM	
	Examiner			e street and number) CENT CENTE	R & NU	RSING HO		City, Town, or I	Location of Death	Death 4c. County of Death BALTIMORE		
	Funeral Director	5. Sociel Security 215–01	Number 6. 5 -8162		e (In yrs. lest	1 4444	der 1 Yeer	Hours Min.			Birthplace (State or Foreign Country)	
Т	fand ow III	Usual Residenca 10a. State	of Decedent 10b. County		10c. City, To	own or Location					10d. Inside City Limits	
	vith the Man or 28a-f sh he notified. Director	MD	N/A		3601	FORDS I	AND #C	306	BALTIMOR			
	with the not a Liberal	10e. Street and N 3601 F	umber ORDS LANE	#806		101. 2	Zip Code		10g. Citizen of What Country?			
020	ors after death with the Marylan all, or farms 23s or 28s-8 show Examiner must be notified at by Funeral Director	11. Merital Status	rried 2 Married	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		1111	cedent of Hisp pecify Cuban,		pecify Yes or No- to Rican, etc.)			
200		(Spi	15. Decedent's En		10	6a. Decedent's Us (Give kind of	work done du	on ring most of wor	rking	16b. Kind of Busin	ess/Industry	
21215-0020	bed within 72 to tygiene. we then "neturn it, the Medical J Completed	Elementery/Sec		College (1-4or 5	i+)	HOUSEWIF				OWN HO	ME:	
	tal Hyg d other event, I	17. Fefher's Nem	(First, Middle, Last)		11000001111		8. Mother's Nar	me (First, Middle,			
Maryland	Menta Menta mrked mrice	JACOE			-	OSCHEROF		BESSIE			PERSMIDT	
Mar	d 2 sh th and 7 is m traum		Neme/Reletionship (1					RE, MD 2		
re,	of Heal Hem 2 r other	20a. Method of Di	sposition		20b. Pleca	of Disposition (A	Veme of		Dete	20c. Location - Cit		
Baltimore	Pages ment: If its ury or o		2 ☐ Cremation 3 ☐ 5 ☐ Other (Specil	Removal from State (y)		SINAI CE			10/11/00	OWINGS	MILLS, MD	
Ball	Departing any inj	21. Signature of	uneral Service Val	w Louis			and Address REISTE				BROS., INC. E, MD 21208	
	Physician /Medical Examiner Examiner Examiner	Immediate Cause disease or condit resulting in deeth	(Final ion)	ab	Q Due to (or es	a consequenca o	tage				Interval Between Onset and Death	
Box 68760,	g physicia as the bur	Cause (Disease of that initiated ever resulting in deeth	or injury its	c	Due to (or as	a consequence o	of):					
O. B	at the death certified by the attending stached for use a Physician/M	Part II. Other sign	ificant conditions	contributing to deeth b	ut not resultin	g in the underlying	g cause given	in Pert I.	23b. Did to	obacco use contri	buts to the cause of death?	
σ.	that the sed by the detache		Dehyd	rutun					1 D Y	'ss 2□ No 3	Probably 4 Unknown	
of Vital Records,	The law requires that the death certains has been signed by the attendin page 2 should be detached for use Completed by Physician/N		Atrial	Fab					24e. Wes a perfor		24b. Were eutopsy findings available prior to completion of cause of deeth?	
<u>e</u>	certificata has rector, page 2 Be Comp								10Y		1 ☐ Yes 2 ☐ No	
\rightarrow	Physician: The laths certificate he ral director, page TO Be Com.	25. Was case reference? 1 Yes 2	No Medical	Hospital: 1 ☐ Inpatie	ant 2 FR	/Outpatient 3□	Other		ath (Check only or dome 5 ☐ Resid	ne) enca 6 □Other	(Specify)	
		27. Manner of De 1 Natural 2 Accident		28e. Date of Inju (Month, De		b. Time of Injury	28c. fnjury e Work?	44	1	ow injury occurred	geoliji	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 Suicide 4 Homicide	6 Could not b	9 Ope Diese of Ini	ury - At home c. (Specify)	, farm, street, fact	tory, office		28f. Location (S City or Tow		or Rurel Route Number,	
	To the Hospital within 24 hours a To the Funeral completely filled	29a. Certifier (Check only one)	1 ☐ Certifying Pt 2 ☐ Medical Exar	niner: On the best of end menner sta	examinetion	dge, deeth occurre end/or investigati	ed et the time ion, in my opi	, date end place nion, death occu	a, and due to the durred at the time, o	euse(s) end menn late end place, and	er es steted. I due to the cause(s)	
	within 70 the comple	29b. Signeture er	d fittle of certain	ond mariner sta	in a	1	29c. License	number	-	29d. Date signed (i		
			////	EL .	my		12	7569		10/10	0/00	
	9	30. Neme end ad	ress of person who	completed chuse of d	eeth (Item 23	a) (Type, Print) /83\$	6	reene	Tree	Rd &	5200	
	State Registrar	31. Date filed (Mg	nin Day, Year)	32. Registre	er's Signeture مصمر	& ho	onks					

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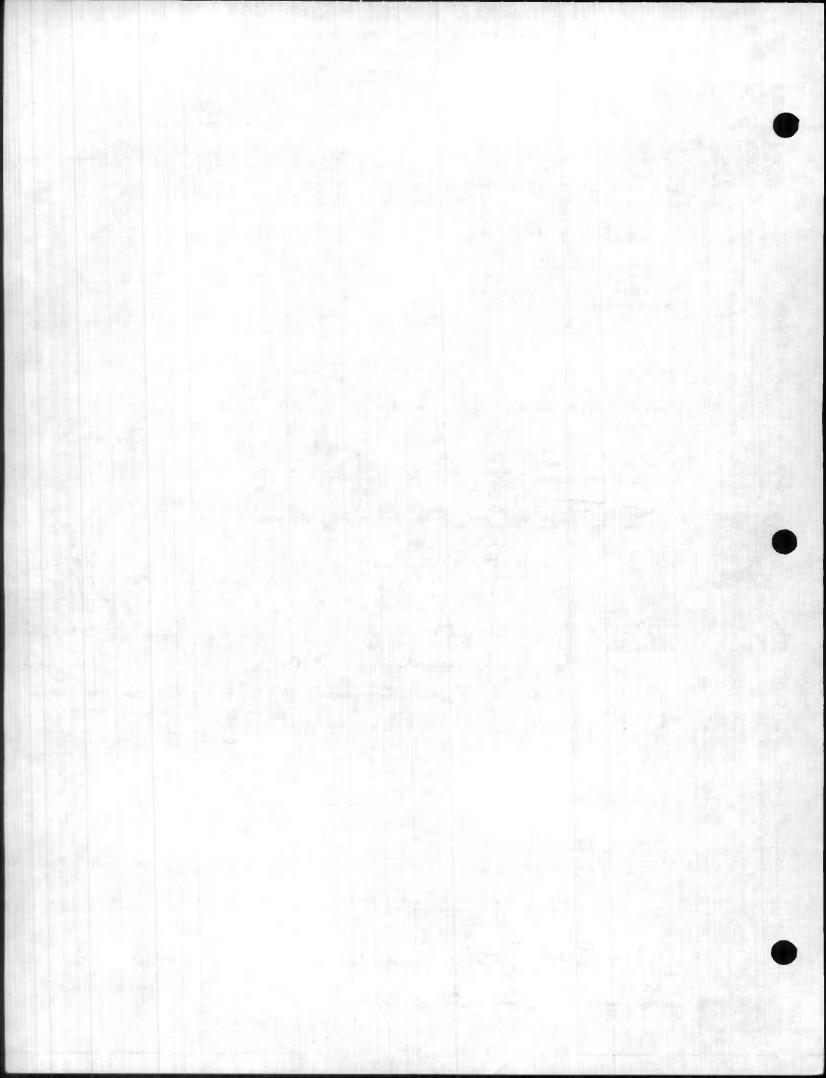
Registrar



State of Maryland / Department of Health and Mental Hygiene

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				Certificate of	Death	Reg.	No.	06104				
	E-101-37	Decedent's Nama (First, Middla, Last)				2. Deta of Death Month	Day Yaar	3. Tima of Death				
0	Physician / Medical	Edward J. Wellner				October	5 2000	11:15 AM				
	Examiner	4a Facility Neme (If not Institution, give street and num	ber)		4b. City, Town, or Loc		4c. County of Death					
		Stella Maris Hospice at Mercy Hos	pital		Baltimore	e	N/A					
	Funeral Director	5. Sociel Security Number 6. Sex 1 № M 2 □ F	. Age (In yrs. lest birth 94 Y	mdey) If Undar 1 Yeer Months Days	Hours Min.	8. Dete of Birth (Month, Day, Youne 28	9. Birth	plece (Stete or Foreign ntry) MD				
h	P	Usual Residenca of Decedent	10.00.7									
	a how	10a. State 10b. County	10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 1 No				
	the Municipal noting	MD Howard	Ellicot		8-7-1-1-1							
	with the Meryland a or 28a-f ahow Libe nothing at	10e. Street and Number		10f. Zip Code		10g	ntry?					
	₹ % ¥ 62	8430 Mitzy Lane	21043				USA					
	trems trems	Armed Ford		 Was Decedent of I If Yes, specify Cub 	Hispanic Origin? (Spec ean, Maxican, Puarto F	Rican, etc.)	14. Race - Ameri Bleck, White,					
21215-0020	by	1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 If Yes, Give Yaar or Dat		1□ Yas 2⊠ No	Specify:		Specify: Whi	te				
5-0	72 ho	15. Decedent's Education (Specify only highest grade completed)	16a. i	Decedent's Usual Occur Give kind of work dona	pation during most of workin	16	b. Kind ot Business/In	dustry				
21	ed within 72 ho ygjene. wr than "naturi ft, tr. Wocall Completed	Elementery/Secondary (0-12) College (1-	for 5+)	(Give kind of work dona during mo lifa. DO NOT use retired)								
	Hygier the mrt. the Cor	10 0	Ir	spector			Automotive					
pu	0 0 > 0	17. Father's Neme (First, Middle, Last)			18. Mother's Name		iden Sumama)					
7	should be not Mentel marked of marke	Frank Wellner		Antionia								
Maryland	0 6 8 8	19e. Intorment's Name/Relationship (Type, Print)		Mailing Address (Stree								
	s 1 end of Heelth fram 27 other to	Susan Gershman/Daughter		30 Mitzy L	ane, Ellic							
Or	00 -	20a. Method of Disposition 20b. Plece of Disposition (Neme of cematary, cremetory or other place) 20c. Location - City or chemical place										
tim	nit. Pa autmen ortant: Injury	4 Donation 5 Other (Specify) Oak Lawn Cemetery 10-7-00 Baltimore 21. Signature of Funeral Robert Licensee 22. Name and Address of Facility										
Baltimore,	permit. Page Department of Important: If any Injury or anse.	21. Signature of Funeral Price Licensee		Cvach/R 1211 Chesa		meral Ho	me e MD 212:	37				
		23a. Part 1: Enter the disease, or complications thet ca shock, or heart tailure. List only one cause on ea	used the death. Do no	ot enter the mode of dy	ing, such as cerdiac or	respiratory arrest	· III ZIZ	Approximate Interval Between				
	Physician	Shock, of fleat tailule. List only one cause on ea	GI IIII					Onset and Death				
	/Medical	Immediata Causa (Final disease or condition	Sonal In	110				31				
	Examiner	resulting in death) e1			- 0							
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	axecuted in end ital-transit	Sequentially list conditions,	Due to (yr as a co					A 1				
0,	e axe	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	1/14					Lweets				
68760,	artificate be assecuted ing physician end e es the bunal-transit	that initieted events resulting in death) Lest	Due to (or es a co	onsequance of):	2. 0			9				
	death certificate be a attending physicia of for use es the bur iclan/Medical	d	Lutraci	anial	bleed		3 weeks					
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Records	een sign rould be	l l				24e. Was en		Vere eutopsy tindings vailable prior to				
00	w requir should should					performe	C	omplation of causa t death?				
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a	certificate rector, pag	25. Was case reterred to medical			26. Place of Death		24110					
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Division of	2 2 2 7	27. Manner of Death 28e. Date of		me ot 28c. Inju		8d. Describe how		" I parice				
o	ding it. Aftar stuner	1 ☐Natural 5 ☐ Pending (Month 2 ☐ Accident investigation	, Day Year) In		Yes 2 No							
15	Attending or death. octor: Attention the fune fune fune fune fune fune fune fun	3 ☐ Suicide 6 ☐ Could not be	t Injury - At home, tan	m, street, factory, office	2		et end Number or Rui	ral Route Number,				
Ö	din din	4 Homicide building	g, etc. (Specify)			City or Town,	State)					
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:	29e. Certifier 1 Certifying Physician: To the b										
	the Ho hin 24 I the Fu npletely	(Check only one) 2 Medical Examiner: On the base	is of axamination and tratated.	or investigation, in my	opinion, death occurre	od at the time, date	and place, and due	o the cause(s)				
	Withir Comp	29b. Signeture and title of certific	29d	. Date signed (Month	, Dey, Year)							
		1 Colon	1	DY	1908		10/0/1	\mathcal{D}				
	0	30 Name and address of person who completed asse	of deeth (Item 23e) (1	Type, Print)	0	. 0 11	. 141	A 1 A 01 :				
		1 Javid Scharttus	808	5 Carl	us Street	of to	t. mD	21224				
	State	31 Amerilled (Ashring Annies) President	gistrar' Signature	rocker	0			1				
ì	Registrar	001 1 4 2000	/									



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 600 pm DEBORAH LYNN WHEATON 2000 october /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Franklin Square Hospital center Kosedale Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2X F 45 Jan 24, 212-74-1026 DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Sfete 10b. County 7 is marked other than "natural", or itsms 23s or 28s-f shor treumstic avant, the Medical Examinar must be notified at MD Baltimore 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 Mace Avenue 21221 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 11. Marital Stetus 1 ☐ Yes 2 No No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 0 canning press operator 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Heelth and Mentel Hy Important: if Item 27 is marked oth any Injury or other treumstic avam ands. 17. Father's Name (First, Middle, Last) Kathryn Sherman Alvin W. Wheaton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Carol Palmerton/friend 8320 Harrison Blvd Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) in State in state 2) Signature of Funeral Service Licenses Ronald S, Wade, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street an Baltimore, MD 21201 28a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediefe Cause (Finel disease or condition resulting in death) /Medical Colon cancer « Metastatic 2 years Examiner Due to (or es a consequenca of). Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 70 3 □ Probably 4 □ Unknown Be Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? page 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospifal: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Do 1 Depatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28b. Time of 28c. Injury of Work? 28d. Describe how injury occurred 1 Distural
Accident 5 Pending Investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steled. 29e. Certifier 29d. Date aigned (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Himore Maryland 21237 9000 Franklin Square Drive ard Navill MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Beneva Registrar

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borah

1) rector

P.O. Box 68760,

of Vital Records,

Division

or Attending Physician:

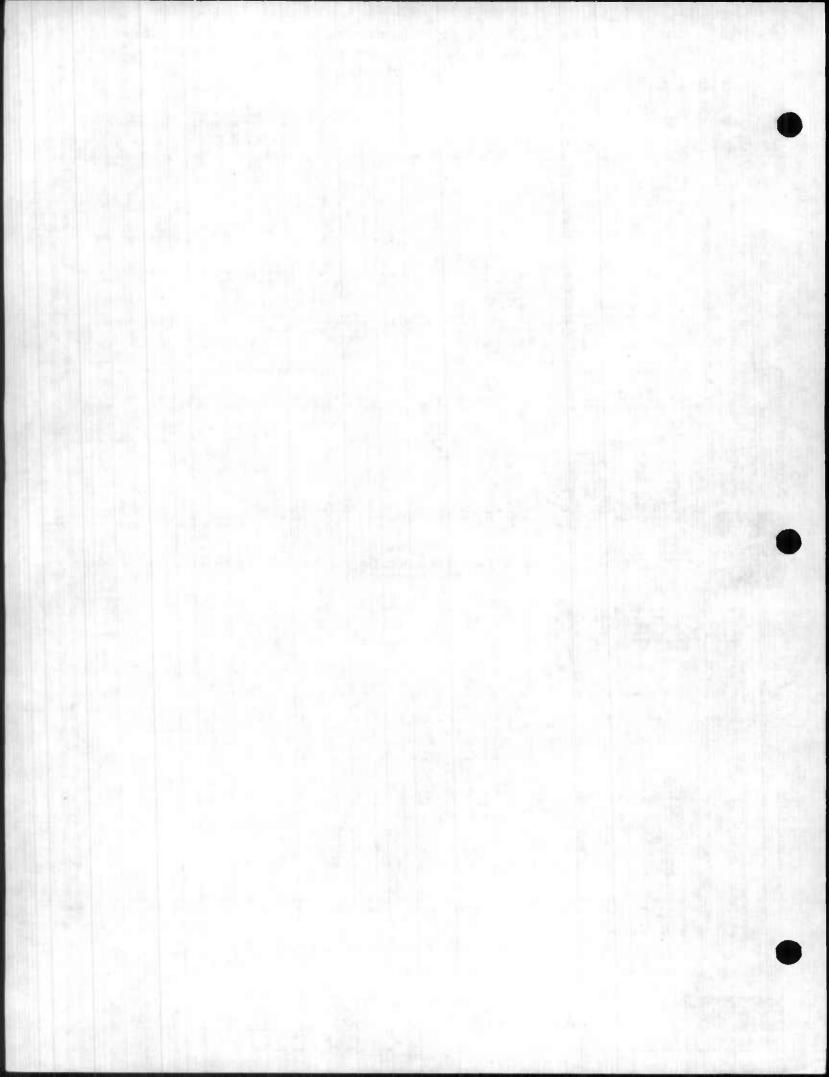
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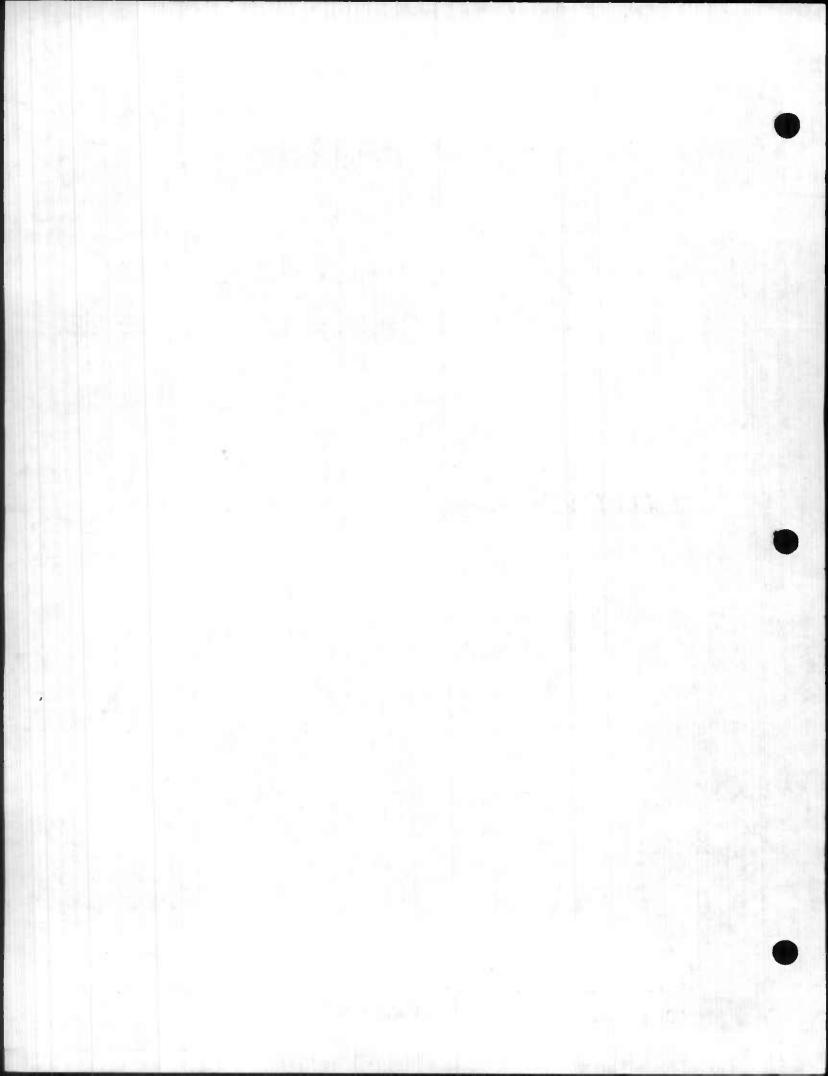
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				Certifica	ate of	Death		Reg. No.)) (190
	1. Decedent's Nema (First, Middle, Last	t)					2. Dete of Dec	oth		Time of Death
Physician	ARTHUR	J.	WHALLEY				October	Day 6 20	Yaar 200	0140
/Medical Examiner	4a Facility Neme (If not institution, give	street and number)				4b. City, Town, or		- 1		
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uneral	5. Social Security Number 6. Se		(In yrs. last birti	hday) If Und Month	dar 1 Yaar s Deys	If Under 24 Hrs Hours Min.				(State or Foreign
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	Usuel Rasidence of Decedent 10a. Stata 10b. County		10c. City, Town	or Location					104	Inside City Limits
28a-f shownorth ed		MODE	Too. Oily, Town	Or Eccation		HDOW 1000				Yes 2XXVo
y Funeral Director	MD BALTI	MORE		404.7	EDGEWOOD			10g. Citizen of V		
5	10e. Street and Number				10f. Zip Code			Tog. Citizen or v		
Funeral	1224 CHIPPER DR	12. Was Decedent B	ver in H S	13 Was Dec	redent of l	21040		14 Rec	U.S.A	
L L	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Yes, sp	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒No Specify:		to Rican, etc.)	Bled	ck, White, etc.	
by	3 Widowed 4 Divorced	If Yes, Give Yeer or Detes: I		1 ☐ Yes				Specify	WHITI	E
	15. Decedent's Edu	ucation 16a. Decedent's			suel Occup	pation		16b. Kind of B	usiness/Indust	ry
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10	ARTHUR	WHALLEY			MILDRED (LETSCHIN)					
	19a, Informent's Neme/Relationship (T)	ype, Print)	19b.	Mailing Addre	ess (Street	t and Number or R	ural Route Numbe	or, City or Town,	State, Zip Co.	de)
other traumatic	STEVEN WHALLEY (SON)		24 CHI		DRIVE E	DGEWOOD,		21040	
	20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐ F	Removel from State	20b. Place of cematers	Disposition (N y, crematory or	veme of or other pla	ice)	Dete	20c. Location -	City or Town,	Stete
	4 Donetion 5 Other (Specify,	HILL C	LL CEMETERY 10-9-00 BALTIMORE, MD							
any injury o	21. Signature of Funeral Service Licensee 22. Name end Address of Facility CVACH/ROSEDALE FUNERA									
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been signed by the attending physician end map physician by the attending physician end map physician for use as the bunal-transit map physician/Medical Examiner	Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or as e consequence of): Due to (or as e consequence of):									
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BeC	25. Wes case referred to medical		ETS-S			26. Plece of De	eth (Check only o	one)		
2	examiner? 1 Yes 2 No 27. Menner of Deeth 1 Netural 5 Pending investigation	Hospitel: 1 Inpatie 28a. Dete of Injur (Month, Day		ime of hjury	28c. Inju		Home 5 Resident	dence 6 Oth		
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within the negletar or attending represent. The law, within the A hours often death. To the Funeral Director: After this certificate has b completaly tilled in by the tuneral director, page 2 si Medical Certification: To Be Comple	29b. Signeture and title of gertifier			2		se number		29d. Data signe	ed (Month, Day	, Year)
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2 8	30. Name and address of person who c	ompleted cause of de	eeth (Item 23a) (Type, Print)						
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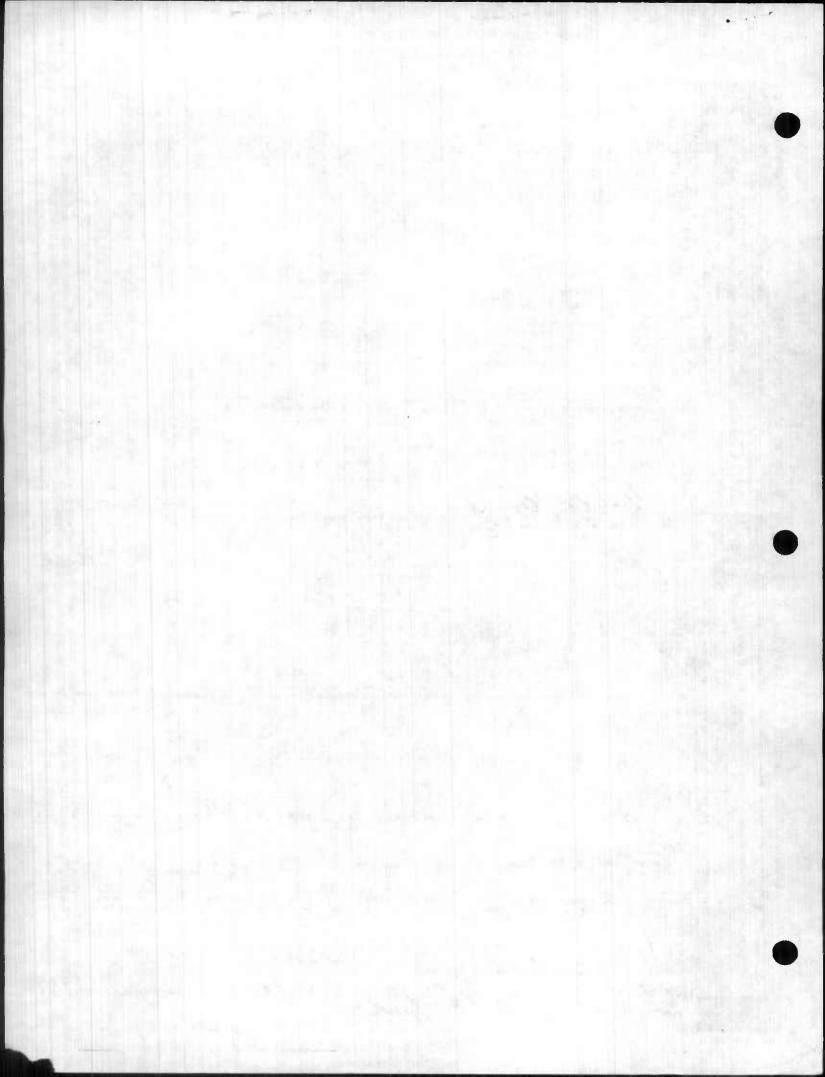
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State of Maryland / Department of Health and Mental Hygiene

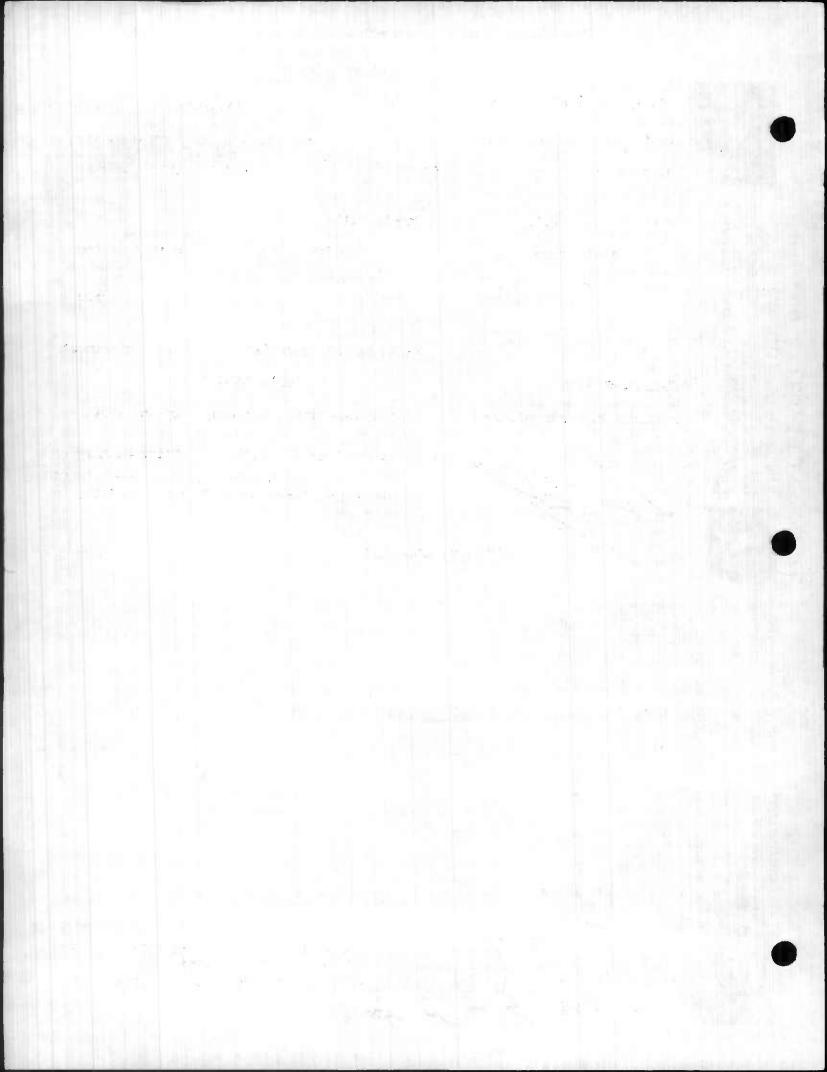
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d 2 st d 2 st d 2 st T ls m traum		19a. Informant's Name/Ralationship (Dorothea	Holmes							City or Town,			
Para d		20a. Mathod of Disposition	20	b. Place of D				Da		20c. Location -			
ages ant of		1 Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Specif	removal from Stata					Com		3-2000			_
mil. Pages 1 spartment of Hs portant: If iten iv injury or oth	1	21. Signature of Earleral Service Licer					ass of Facility			, Mar			
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		23a. Part1. Enter the disease, os com shock, or heart failure. List oply	plications that caused the	daath. Do not	antar tha m	oda of dyi	ng, such as o	cardiac or rasp	oiratory arra	ist,	1	Approximata Intarval Batwe	een
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/Medic	_	Immediate Cause (Final disaasa or condition	.Introcro	oial	Blee	nibo	a				3	days	
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bed les	Examiner		b		1 = 1								
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ficate be executed physician and as the buriel-transit	edical	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury c. Due to (or as a consequence of):											
2 00		rasulting in death) Last											
eath card attandin			d						net Stda.				A A A
the d	hysi	Part II. Other significant conditions of	ontributing to death but no	rasulting in th	na undarlying	cause gr	van in Part I.		236. Dia to	bacco uae co		the cause of ably 4 □ U	
es that igned b	by P								1011	292110	0_7100	iory 400	TIKITO I
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cartificate		25. Was casa rafarred to medical					26. Placa	of Death (Chi	eck only on				-
	TO B	examinar?	Hospital:	2 ER/Outp	atient 3 1	DOA OI	har: 4 Nur	rsing Homa	5 🗌 Raside	nca 6 Oth	ar (Specify))	
- D 0 2	ü	27. Manner of Death 1 Natural 5 Panding 2 Accidant Investigation	28a. Data of Injury (Month, Day Yes	28b. Tin Inju		28c. Inju Wo	ny at ork?]Yas 2 □ N		Dascribe ho	w injury occur	red		
Tor Attending after death. Director: After din by the fune	Certification:	3 Suicida 6 Could not b 4 Homicide detarmined	28a. Placa of Injury - building, atc. (Sp	At homa, farm	, straat, facto	ory, office			ocation (St City or Town	reet and Numb n, Stata)	er or Rural	Routa Numb	er,
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft complately filled in by the fun	edical C	29a. Cartifiar (Check only one) (Check only one)	ysician: To the best of my niner: On the basis of axer and manner stated.	knowledga, o mination and/o	daath occurre or invastigation	ed at tha ti	ima, data and opinion, daat	d place, and d th occurred at	ua to tha ca tha tima, d	ausa(s) and ma ata end placa,	innar as sta and dua to	ited. tha causa(s)	
o the	2	29b. Signetura and titla of cartifier) 2	9c. Licen	sa number		2	9d. Data signe	d (Month, E	lay, Year)	
F 3 F 8		Hound a	und	MY			122	37		10-3.	00		
1141		30. Nama end addrass of person who	compiled cause of deeth	(Item 23a) (Tr	/pe, Print)	0		, (
5-11+1		Haider Farraf m	D 9000 From 32. Ragistrar's S	acklin	Sain	re D	rive .	Baltin	nore	Marie	land	2/23	7
	State	31. Data filed (Month, Day, Year)	32. Ragistrar's	enatura	200 1/2	1		1111		J			
	istrar	OCT 1 2 2000	Denie	19									

DHMH 16 Rev 6/95



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		Decedent's Name (First, Middle, Last))	(Certifica	ile of	Deall	2. Dete of De	Reg. No.	3. Ti	me of Death	
	Physician /Medical	Owen McClintic	ck Akers					Month	Day IBER 27,	Yeer	:03 A.M	
	Examiner	4a Fecility Name (If not institution, give					4b. City, Town, or L					
		MALCOLM GROW MEDI			CAMP SPR					CE GEORG		
	Funeral Director	5. Social Security Number 6. Set 710 14 9259 Usual Residence of Decedent	M 2□F	In yrs. lest birth	Month		Hours Min.	8. Date of Bir (Month, Da Oct 26	1915	9. Birthplece (S Country) Kansas	tate of Poreign	
	deeth with the Marylend ms 23e or 28s-f ehow crast be notified at	10a. Stete 10b. County	11	Oc. City, Town					10d. Inside Ci			
	with the Mar to or 28a-f e	MD P.(3.	Te	mple H						Yes 2 No	
	Nith th	10e. Street and Number			10f. 2	Zip Code 2074	40	4 10 1	10g. Citizen of V	Vhat Country?		
	ss 234	6305 Mark Drive	12. Was Decedent Eve	ar in 11 S	13 Was Day			ecify Yes or No		e - American Indi	an.	
	b 22 5	3 ☐ Widowed 4 ☐ Divorced	Armed Forces? XXXYes 2 \(\text{No}\) No if Yes, Give Yeer or Detes:	, iii 0,3.		3. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 Funo Specify:				k, White, etc. White		
	od within 72 horygiene. Set then "natural, it is Moderal.	15. Decedent's Edu (Specify only highest gred	cetion e completed)	16a. D	Decedent's Us	suel Occup work done	pation during most of work d)	king	16b. Kind of Bu	usiness/Industry		
	d withing diene.	Elementery/Secondary (0-12)	College (1-4or 5+)				Scientis		U.S. C	Covernmen	nt	
-	d be file ental Hy control of the co	17. Fether's Name (First, Middle, Last)					18. Mother's Nam Belle	e (First, Middle) (UNKNOW		10)		
AKERS	Maryland 21215-0020 d 2 should be filed within 72 hours aff the and Mental Hygiens 17 le marked other than "natural", or traumatic event, the Medical Frain To Be Completed by F	19a. Informent's Name/Relationship (Ty Patricia A. Carls			Meiling Addre	ess (Street	end Number or Rui Drive, Wh	rel Route Numb	er, City or Town,	Stete, Zip Code) 1 20906		
M.	Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health end Mental Hygininportant; if item 27 le merked other than any injury or other traumatic event, trause ange. To Be Compi	20a. Method of Disposition 1 □ Burial □ Committon 3 □ R 4 □ Donation □ Other (Specify)		20b. Plece of D	, cremetory o	emetory or other place)				n - City or Town, State ton, Maryland		
OWEN	Baltimo	21. Signature of Superal Service License			22. Name	end Addre	ess of Facility Lee a Ferry R	Funera				
NAME		23a Cart Effer the disease, or coords shock, or heart failure. List only or	cations that ceused the	e death. Do no	1		_			Appro	ximate al Between	
NAJ	Physician /Medical	Immediate Cause (Final disease or condition	SEPSIS-								and Death	
cr	Examiner	resulting in death) Due to (or es e consequence of):										
	60, be avacuted icien end burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of):										
	8 5 5 8 W											
	= 00		d									
	Geath death	Part II. Other significant conditions cor	ntributing to death but r	not resulting In t	the underlying	g ceuse gi	ven in Pert I.	23b. Dld	tobacco use co	ntribute to the ca	sues of death?	
	S, P.O. Box as that the death cent and goed by the attending be detached for use by Physician/M							10	Yes 2□ No	3 Probably	4 ☐ Unknown	
	cord requir been si should							24e. Was	an eutopsy omed?	24b. Were eut available completio of death?	on of ceuse	
	The la							1X	Yes 2□No	1 ☐ Yes	20 No	
	/ita	25. Was cese referred to medicel					26. Place of Dea	th (Check only	one)			
	hysic of this countries and direction To	1 ☐ Yes 2 No		2 ER/Outp		DUA			dence 6 □Oth			
	sion seth.	27. Manner of Deeth 1 Natural 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Y	rear) 28b. Tir	me of ury M	28c. Inju Wo 1	ry et ork?] Yes 2 □ No	28d. Describe	how injury occur	red		
	Division of the standing P is ofter deeth. The standing P is ofter the standing of the standi	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury building, etc. (- At home, fam Specify)	n, street, fact	ory, office		28f. Location (City or To	Street and Numb wn, Stete)	per or Rural Route	e Number,	
	Division of Vital Recomplete to the Hospital or Attending Physician: The law within 24 hours efter deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Comp		sicien: To the best of mer: On the basis of ex end manner stated	camination and/	death occurre for Investigation	ed et the ti on, in my	me, date end place, opinion, death occur	and due to the rred et the time,	ceuse(s) and me date end place,	enner es stated. end due to the ce	ause(s)	
	To the comp	29b. Signature and title of certifier		1	2	29c. Licen	se number		29d. Date signe	d (Month, Dey, Y	'eer)	
	(0)) -=	A	2		ME 70064				ER 27, 2	000	
	(15)	30. Name end eddress of person who co PEDRO A. ALONSO, M					G/1050 W. WS AIR FO			0762-660	0	
	State	31. Dete filed (Month, Day, Year)	32. Registrar's	Signeture	2							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** SEFTEMBER 21 2000 8:25Am CELESTE ANGELA ARNOLD /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Glen Burnle 7. Age (In yrs. last birthday) unde 5. Sociel Security Number If Under 1 Yeer | If Under 24 Hrs. | Birthplece (State or Foreign Country) 8. Dele of Birth (Month, Dey, Year) 6. Sex **Funeral** Days Hours Months 1 M 2 F 216-38-4965 Director June 24, 1916 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland t ☐ Yes 2 ☐ No Anne Arundel Severna Park Director 10a. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò 118 Arundel Beach Road Funeral 21147 United States Race - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Merried 2 Married Yes 2 No 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-002(₩idowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker. Domestic 17. Felher's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be and 2 should be eaith and Mental John Thomas White Mary Ethel Kohlhaus 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole A. Nusbaum/Daughter 331 Sturtons Lane, Pasadena, MD 21122 altimore. 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Pages 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel Irom State 4 ☐ Donetion 5 ☐ Other (Specify) 9/26 Hampstead, Maryland Carroll Cremation 21. Signeture of Faserel Service Licansee 22. Name end Address of Fecility 91 Willis Street Myers Funeral Home Westminster, MD 21157 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart leilure. List only one cadse on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediete Ceuse (Final PNEUMONIA disease or condition resulting in deeth) Examiner Due to (or as e consequence of): Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): P.O. Box 68760. Physician/Medicai the Due to (or es e consequence of): USB 85 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Probably 4 Unknown 1 Yes 2 No DOSTRUCTIVE Philmo warry DISEASE Records, à page 2 should be 24b. Were autopsy lindings available prior to completion of cause of death? Be Completed 24a. Wes en eutopsy 20 No 1 Yes 1 Yes 2 No certificate Division of Vital or Attending Physician: funeral director. 25. Wes case relerred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient Medicai Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: Al investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier completely (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ayoun Dustum. 301 HB3 TM BRu 31. Dete liled (Month, Dey, Year) State

29b. Signeture end title of certilier

MeTungi

SEP 25

Registrar **DHMH 16 Rev 6/95**

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ORIGINAL

BRUVE

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32. Registrer's Signeture

29c. License number

Glen Burnie, no.

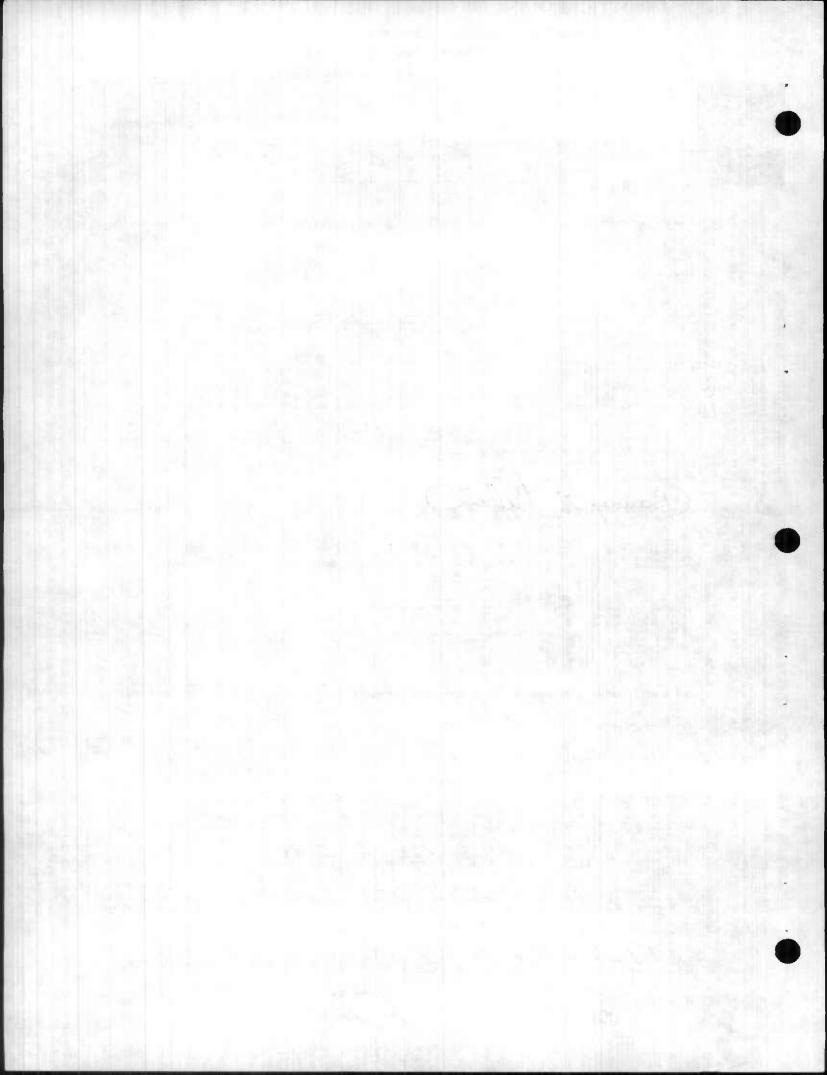
29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)	2. Date of Death							
/Medical		2. Date of Death Month Day		3. Time of Death					
	Melvin Gray Alderman OCTOBER 1, 2000 12:2								
	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	ocation of Death	4c. County of De	ath					
	EASTBOUND CHARLES STREET EAST OF FARM ROAD LAPLATA	CHARLES							
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 2.1.7 2.0 0.7.2.4 1 XM 2 F 7.4 Yrs. 7. Age (In yrs. last birthday) Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. E	irthplaca (Stata or For Country) St Virgini					
Director	217-20-0734 TXM 2DF 74 Yrs.	6/1/19	26 We	st virgini					
No se	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Lin					
tiems 23s or 28s-f shortness must be notified at Furneral Director	Virginia N/A Newport News			1 XYes 2					
ire par	10e. Street and Number 10f. Zip Code	10	g. Citizen of What	Country?					
al D	7303 Roanoke Avenue 23605		U.S.A.						
The The	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puarlo	ecity Yes or No-	14. Race - Ar Black, W	naricen Indian,					
F. F.	1 Never Married 2 Married 1 N Yes 2 No 1 Yes 2 No Specify	, 110-11, 010.,	Specify:	1110, 010.					
LExa d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 22		Wr	ite					
nath edica	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 1	6b. Kind of Busina	ss/Industry					
ygiene. ver then rt, the Me Compli	Elementery/Secondery (0-12) College (1-4or 5+) 12 College (1-4or 5+) Instructor/Trainer		Civil Ser	wico					
	17. Father's Name (First, Middle, Last) 18. Mother's Name			VICE					
ental h	James Albert Alderman Shrilda								
2 E E	19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Run			Zin Codel					
th and 7 is me traum	Cindy A. Brown, daughter 208 Mayflower Drive,			23701					
Hoal Day			Oc. Location - City						
10 10 10	1 Burial 2 Octremation 3 Removal from State Dominguity or other place)	771							
444	4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Pen		Newport N						
Depa		44 Warwi	ck Boulev	ard					
	New 23 Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac shock, or heart failure. List only one ceuse on each line.	port New	s, Va. 2	Approximate					
xaminer	disease or condition resulting in deeth) Due to (or as a consequence of):								
ng physicien and est the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of):								
ed by the attending detached for use e	Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.			uts to the cause of de					
pege 2 should be de Completed by P		24a. Was ar perform		b. Were autopsy finding available prior to completion of cause of death?					
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certificate rector, per	25. Wes case referred to medical 26. Place of Deet	th (Check only one	9)						
this ce		oma 5 Reside	nce 6 AOther (S	pecify) SCENE					
ther the	27. Manner of Death 1 Natural 5 Pending 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury Work?	28d. Describe ho	w injury occurred	subjet of					
or deeth. ctor: Afte by the fune iffication	2 Accident investigation 10/01/00 /220 1 1 Yes 24No	~-C	cid 7	n irenacieta					
2 +	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str.	state) & T	Rural Route Number					
Tied O	roodway	J/mt es	et y Farm	way Chul					
within 24 hours af To the Funeral DI completely filled in	29a. Certifier (Check only one) 1□ Certifying Physician: To the best of my knowledge, deetly occurred at the time, date and place, and manner stated. and manner stated.	and due to the ce red at the time, da	ruse(s) end menner ite and place, and o	as stated. Majure to the ceuse(s)					
within 2 To the comple	29b. Signatura and titla of certifier 29c. License number	29	d. Date signed (Me	onth, Day, Year)					
200	17/ -0. 4 /6 0 O.C.M.E.		CTORED 2	2000					
1000 A	1 The sale of the Control of the Con	O	CTOBER 2,	2000					
N COO	1 the way in the same								
To To	30. Name and address of person who completed ceuse of peath (Item 23a) (Type, Print) THE NORE Mckif 111 Penn Street, Balt	imoro M	anyland 3	1201					

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year **Physician** 1353 Ethel Irene Alderman October 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner George's Hospital Prince cheverly Georges If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Year 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Days Months 1 M 2 XF Yrs. 214-28-2522 68 Director Maryland Usual Rasidence of Decedant 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yes 2 No Directo Newport News 288-1 Virginia N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or flams 23s or must be 23605 7303 Roanoke Avenue U.S.A. Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forcas? 14. Race - American Indian, Black, Whita, atc. 1 Yas 2 No If Yes, Give Yaar or Datas: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: à 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) 12 Collega (1-4or 5+) School Bus Driver City of Newport News 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be h and Mental F 8 Pages 1 and 2 showld Lo Elizabeth Catherine Weeks George W. Shelton 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health as Important: If Nem 27 is any injury or other trau Cindy A. Brown, daughter 208 Mayflower Drive, Portsmouth, Va. 23701 20b. Place of Disposition (Nama of comatary, crematory or other place) Peninsula Funeral Home Crematorium 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removal from Steta 4 ☐ Donation 5 ☐ Other (Specify) 10/5/00 Newport News, Va. 21. Signatura of Funeral Service Licen Peninsula Funeral Home, Inc. 11144 Warwick Boulevard 22. Nama and Addrass of Facility Degree Newport News, Va. 23601 23a. Part1. Entar the disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Motor Vehicle Accident with multiple injuries Immediata Causa (Final disease or condition rasulting in daath) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): 88 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part t. P.0. the signed by t 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. p 24b. Were autopsy findings aveilable prior to Completed 24a. Was en autopsy performed? completion of cause of death? page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: director. Be 25. Wes case refarred to medical 26. Place of Deeth (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28b. Tima of Injury 28d. Dascribe how injury occurred Patient was 28a. Date of Injury (Month, Dey Year) 27. Mannar of Death 28c. Injury et Work? in head on collision 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fu 1 Yes 2 No October 1, 2000 12:20 P invastigation 2 Accidant 6 Could not be datarmined 3 Suicida 281. Location (Street and Number or Rural Route Number of Rort City or Town, State) Roste 6, Warner Still Rort, Charles 28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 ☐ Homicida STREET Hospital 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end menner as steted. edical 29a. Cartifiar 22 medical Examiner: On the basis of axamination and/or invastigetion, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) and menner stated. (Check only one) the th 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifian October 2,

State Registrar

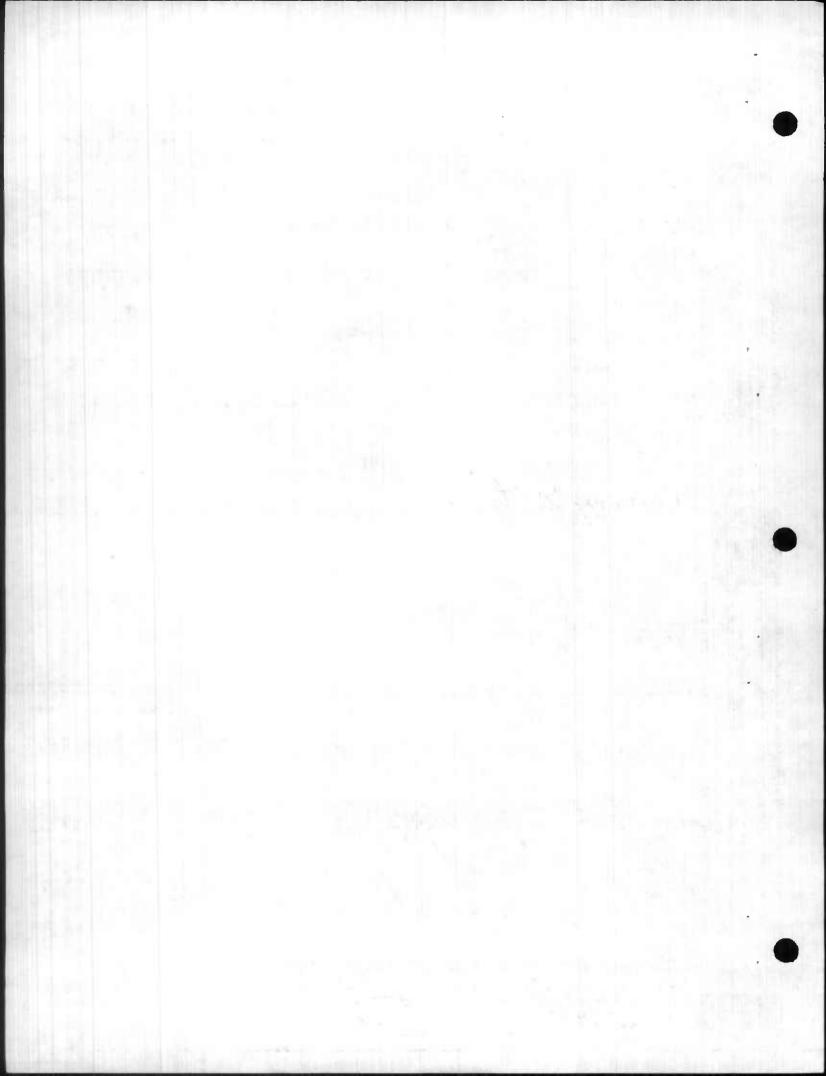
1 2 2000 **DHMH 16 Rev 6/95**

31. Data filad (Month, Day, Year)

30. Nema and addrass of person who completed causa of death (Itam 23a) (Type, Print)

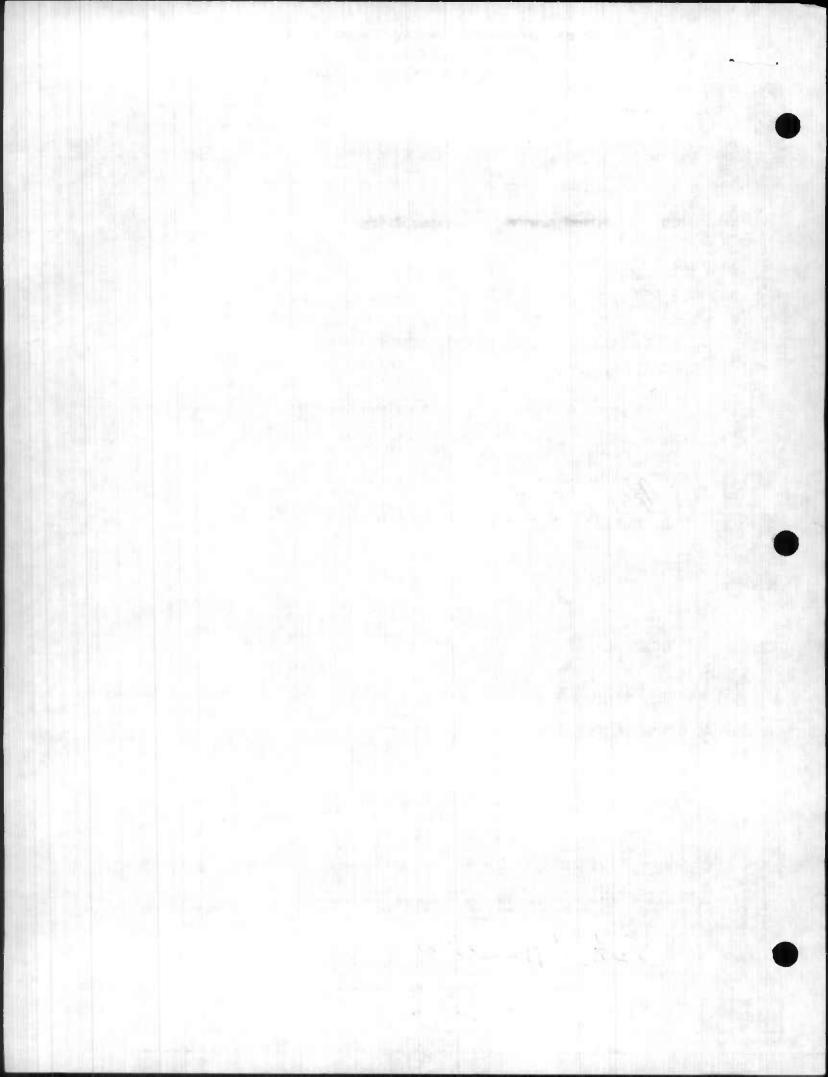
3001 Hospita 32. Registrar's Signatura

Cheverly Huryland 20785



•		State of Maryl		epartment of F Certificate of			giene () (Reg. No.	32202			
	1. Decedent's Neme (First, Middle, La	est)				2. Deta of Dea	ath	3. Time of Death			
Physician	JOSEPH	BRANDON				SEPT.	20, 2000	(ear) 1:00 P.M.			
/Medical Examiner	4a Facility Nema (If not institution, give			3	4b. City, Town, or I						
	6820 Parkwood St	reet			Landover	Hills	Prince	Georges			
Funeral	5. Sociel Security Number 6. S	Mu alle	rs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birt	V_ Year)	Birthplace (State or Foreign Country)			
Director	229-12-0423	81	Yn	3.		9/1//1	919 Pitts	sylvania Cty V			
ms 23s or 28s-1 show	Usuel Residence of Decedent 10e. Stete 10b. County	10c.	City, Town o	r Location				10d. Inside City Limits			
of a Po	D.C.	W:	shing	ton				1 XYes 2 No			
23a or 28a-f ahow unt be notified at rai Director	10e. Street and Number		.on In	10f. Zip Code			10g. Citizen of Wh	et Country?			
38 0	2101 I Street NE		20002				U	SA			
observed by notified and services of the control of	11. Menital Status	12. Was Decedent Evar in	n U,S.		lispenic Origin? (S	pecify Yes or No	- 14. Race -	American Indien,			
	1 Nevar Married 2 Married	Armed Forcas? 1 Yas 2/2/No If Yes, Give	Evar in U.S. 13. Was Decedant of Hispenic Origin? (Spe If Yas, specify Cuben, Mexican, Puerto I			o rican, etc.)		White, etc.			
F. E.	3 ☐ Widowed 4 ☐ Divorced	Yaar or Dates:		1 ☐ Yes 2 ☐XNo	Specity:		Specify:	Black			
nt, tre Medical Completed	15. Decedent's E (Specify only highest gre		(0	ecedent's Usual Occup live kind of work done	during most of wor	king	16b. Kind of Busi	ness/industry			
The light	Elementary/Secondary (0-12)	College (1-4or 5+)		a. DO NOT use retire							
vent, tr	17. Fathar's Nema (First, Middla, Last	0		Truck Drive		ne (First Middle	Private Maiden Surneme)				
Z = W	HEADINESS CHIEFERY	, Joe Fitzgeral	a		100	dna Bra					
ls marke aumatic	19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number,							tate. Zip Code)			
c trau	Dee L. Brandon Wife 2101 I Street NE, Washington, DC 200										
e di	20a Mathord of Disposition 20b, Place of Disposition (Neme of Data 20c, Location - City or										
Department of Important: If it any Injury or page.	1 Bunel 2 Cremation 3 Ramovel from State 4 Donetton 5 Other (Specify) The state of the place of										
		21. Signeture of Fineral Service Licensee 22. Name end Address of Facility									
	ALEXANDER S. POPE FUNERAL HOMES										
	23e. Pent. Enter We disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiretory errest,										
sician	shock, or haart failure. List only	one cause on each line.						Interval Between Onset and Death			
edical	Immediate Ceuse (Finel										
miner	disease or condition resulting in death)										
ner H				nsequence of):							
Sal-transit Examiner	Sequentially list conditions, Due to (or es e consequence of):										
	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury										
the bur	Cause (Disease or Injury c. thet initiated events pure to (or as a consaquanca of): resulting in death) Lest Due to (or as a consaquanca of):										
by the attending price as the state of the s											
attending phy for use as the											
ched ched	Pert II. Other significant conditions of	contributing to death but not	resulting in th	ne underlying cause gi	ven in Pert I.			ribute to the cause of death?			
						10	Yes 2□No 3	3 Probably 4 ☑ Unknown			
d by						24e. Wes	en eutopsy	24b. Were autopsy findings			
should should leted						perfo	rmed?	aveilable prior to completion of causa of death?			
							V 0 [78]				
rector, page 2 b Be Comp	25. Wes case referred to medical				OF Disease of Da	1 1 1		1 Yes 2 No			
director,	examiner?	Hospitel: 1 ☐ Inpatient	2 ER/Outp	atient 3 DOA Ot		eth (Check only o		(Specify Granddaugh			
2 2	27. Menner of Deeth	28e. Date of Injury	28b. Tim	e of 28c. Inju	iry at		how injury occurred				
atlon:	1 Neturel 5 Pending 2 Accident investigatio	(Month, Dey Year	r) Inju		ork?]Yes 2□No						
by the	3 Suicide 6 Could not be determined	200. Plece of injury - A		, street, factory, office		28f. Location (Street and Number	or Rural Route Number,			
= C	4 Homicide building, efc. (Specify) City or Town, State)										
2 2 0	one)	and menner stated.	mietion end/			med et the tinle,					
Com	29b. Signeture and title of certifier	1	11-	29c. Licens			29d. Date signed	(Month, Day, Year)			
5) with	grape	0	#19	9404		Septembe	r 22, 2000			
2)	30. Neme and eddress of person who Scott Sheppard					Washingt	on, D.C.	20010			

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

al Hygiene	0	0	3	2	2	0	

			C	ertificate d	of Death		Reg. No).	04600	
Physician	1. Decedent'a Nama (First, Middla,	Last)		Bear		2. Data of Month	n Da	y Yaar	3. Tima of Death	
Physician /Medical	Wilson	V.		Banks	1	09	3	4 2000		
Examiner	4a Facility Nama (If not institution, Cherry Lane N				La	m, or Location of I	F	rince Ge	eorge's	
Funeral Director	577-16-0171	. Sax 1□xM 2□ F	nga (In yrs. last birtho 94 Yrs	Months Da		Min. 8. Deta control (Montrol Oct.	of Birth h, Day, Year)	9. Birth <i>Cou</i>	placa <i>(Stata or Foraigi</i> Intry) Inginia	
and	Usual Rasidence of Decedant 10a. Stata 10b. County		10c. City, Town o	r Location					10d. Inside City Limits	
a or 28a-f show be notified at	Maryland Prince	George's		G1ena					1 ☐ Yas 2 ☐ No	
23a or 2 unit be or rai Dire	10e. Street and Number 1420 - 7th St	reet		10f. Zip Coo	20706		10g. Ci	United S		
urs after dea	11. Marital Status 1 Navar Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedar Armed Forces 1 Yes 2/ If Yas, Give^ Yaar or Datas	?] No	If Yas, specify (us Decedant of Hispanic Origin? (Specify Yas or Neas, specify Cuban, Maxican, Puarlo Rican, atc.) Yas 2 No Specify:			14. Race - Amaricen Indien, Black, Whita, atc. Specify: Black		
led within 72 hours lygiene. her than "natural", rt, the Wederal E.	15. Decedant's (Specify only highest		10	16a. Decedant's Usual Occupation (Giva kind of work dona during most of working			16b. K	(ind of Businass/I	ndustry	
G . S . D	Elemantary/Secondary (0-12)	Collega (1-4o	r 5+)	a. DO NOT usa ra Truck	tirea) Driver			Self-Emp	oloved	
Se vet	17. Fathar's Nema (First, Middla, La	s) liam Banks				r's Nama (First, M	iddla, Maidar Brook	Sumama)	20)	
and Menti le marked reumatic e										
nd 2 sh lith and 27 le m r traum	19a. Informant's Name/Ralationshi Charles F. Mino		NOT HOLD II	lailing Addrass (Sti		eet, Gle			ip Coda) 20706	
pemil. Pages 1 and: Department of Health Important: If Hem 27 any Injury or other tr andce.	20a. Mathod of Disposition 1 🖾 Burial 2 □ Cramation 3 4 □ Donation 5 □ Other (Spe	☐Removal from Stat	20b. Place of D camatary,	isposition (Nama of cramatory or other ny Memori	f place)	Data	20c. L	ocation - City or T Landove		
permit. Pag Department Important: If any Injury o	21. Signature of Funeral Service Licensea 22. Name and Addrass of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 23a. Partl. Enter tha disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, interval Batween interval Batween and Addrass of Facility Approximate interval Batween interval Batween interval Batween interval Batween interval Batween interval Batween interval Batween interval Batween interval Batween interval Batween interval Batween interval Batween interval Battle Batween interval Batween in									
death certificate be executed to entificate be executed and for use as the buriel-transit to illustrate illustrate is iclan/Medical Examiner	Sequentially list conditions, if any, leading to immediata ceusa. Entar Undarlying Causa (Disaasa or Injury that initieted evants rasulting in death) Last	b	Dua to (or es a con	nsequance of):					7	
leath certification at the second sec										
by the	Pert II. Other significant condition:	A				obacco use contribute to the cause of death Yes 2 No 3 Probably 4 Unknow				
requires the seen signe thould be defected by	Organic	Brain	29ni	aro me		24a.	Was an auto performad?	a	Wara autopsy findings ivaliabla prior to complation of cause of daath?	
certificate has been rector, page 2 s							1□ Yas 2		☐Yes 2☐No	
ector, pe	25. Wes casa rafarred to medicel				26 Placa	of Death (Chack		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2210	
this raid	axaminar? 1 Yas 2 No 27. Mannar of Death 1 Matural 5 Panding	Hospital: 1 Inpa		na of 28c.	Othar: Number of	rsing Home 5 28d. Dase			ify)	
after deatl Director: Jin by the	2 Accidant invastiga 3 Suicida 6 Could no 4 Homicida detarmin	t be 28a. Place of I	njury - At homa, farm atc. (Specify)		1 Yes 2	28f. Loca	tion (Streat a or Town, Stat	nd Number or Ru (a)	ral Routa Number,	
Hospi 14 hou Funer tely fill	29a. Cartifiar (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis and mannar	of axamination and/o	aeth occurred at the Invastigation, in r	a tima, data an ny opinion, daa	d place, and dua to th occurred at tha	tha causa(stima, data an	s) and mannar as ad place, and dua	stated. to the cause(s)	
To the comple	29b. Signatura and title of certifier	1. Mary	light	29c. Lie	canse number	30 9/30/	29d. Da	ate signed (Month	ı, Day, Year)	
0	30. Name end ardrass of person w	no complated cells a of	daeth (Itam 23a) (Ty	(52 Bi	Himore	Avei	40	icl, MO	20707	
State Registrar	31. Data filed (Month, Day, Year)		trar's Signatura							

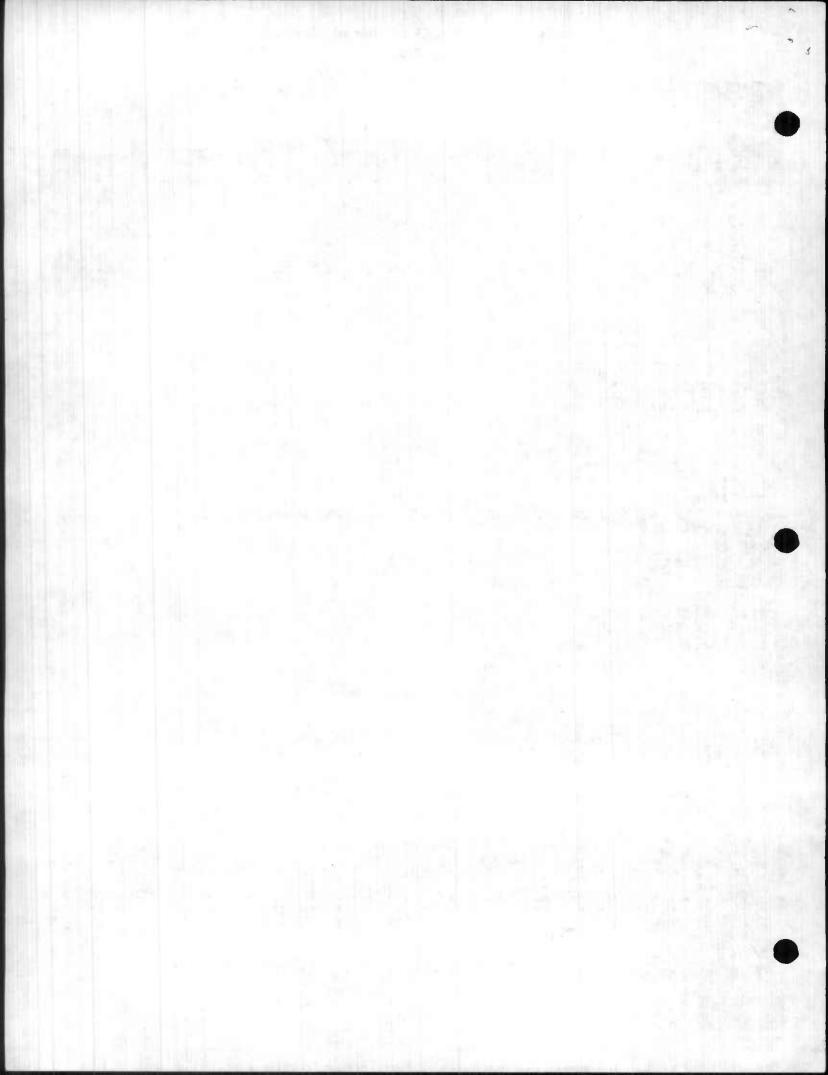
DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 00 32204

				Certificate of	of Death	Reg	ı. No.	0 2 2 0 7		
	1. Decedent's Neme (First, Midd	fle, Last)				2. Dete of Deeth Month	Dey Yeer	3. Time of Death		
Physician /Modical	WILLIAM		BODDIE			September		9:10 PM		
/Medical Examiner	4a Facility Neme (If not institution	on, give street and numb	per)	Entra Merca	4b. City, Town, o	r Location of Deeth	4c. County of Dea	th		
	Washington Ad	ventist Hos	pital		Takoma P	Park	Montgomer	ry		
Funeral	5. Sociel Security Number	6. Sex 7.	. Aga (In yrs. last b	oirthday) If Under 1 Y Months De	ear If Under 24 Hr	8. Date of Birth (Month, Dey, Y	9. Bir	thplece (Stete or Foreign punity) rth Carolina		
Director	579-03-3627 Usuel Residence of Decedent	1 X M 2□ F	86	Yrs.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	June 16	, 1914 Nor	rth Carolina		
al; or tiems 23a or 28a-f show Earniber mail be notified at by Funeral Director	10a. Stete 10b. Count	у	10c. City, To	wn or Location				10d. Insida City Limits		
to	D.C. N/	A	Washi	ngton				1⊠ Yes 2□ No		
Funeral Director	10e. Street and Number			10f. Zip Co	de	100	g. Citizen of Whet Co	ountry?		
aic	257 Rock Cree	k Church Rd	N.W.	20	011	1500	U.S.A.			
ner	11. Marital Status	12. Wes Deced Armed Force	ent Evar in U,S.	13. Was Decedent	of Hispenic Origin? (Cuben, Mexican, Pus	Specify Yes or No-	14. Race - Ama Bleck, Whit			
by	1 Never Married 2 Me 3 ☑ Widowed 4 Divorce	rried 1 ☐ Yes 2	₩ No		No Specify:		Specify: B1			
Completed		nt's Education	16	e. Decedent's Usuel O	ccupetion one during most of w	ndking 16	6b. Kind of Business	/Industry		
once. To Be Comple	Elementery/Secondary (0-12)	est grade completed) College (1-4	lor 5+)	life. DO NOT use re	otired)	Na	ational Ca	apitol		
0		2 yr		Maintenanc	e Supv.	He	ousing Au	thority		
8	17. Fether's Neme (First, Middle	, Last)				ame (First, Middle, Ma	aiden Sumeme)			
2	Unknown				Fannie	e Boddie				
	19e. Informent's Neme/Relation			b. Mailing Address (St						
	Verna B. Drumm	ing - Daugh		422 2nd St						
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion	3 □Removal from St	compl	of Disposition (Name of lary, cramatory or other	place)		Oc. Location - City or			
	4 Donetion 5 □Othar (Harmo	ny Memoria	1 Park	9-30-2000	Landover	, Maryland		
	21. Signeture of Funerel Sarvice	Inc.								
	Delia P	mars &	11.			N.W. Wash		20011		
	23a. Enter the disease, or heart failure. Lis	or complications that cau	sed the death. De					Approximete Interval Between		
Examiner	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	e. <u>CA</u> 6	<u> </u>	e consequence of):	HTIEN	MEAST	AS15 .			
Medical	resulting in death) Lest		Due to (or es a	consequence or):						
3		d						1		
Physician/	Dark II. Other elevidicent conditi	lana aastibusiaa sa dab	th host not requisite		a sives in Bad I	22h Did toh	naca una contribut	e to the cause of death?		
hys	Part II. Other significant condit	,			o given in Pent I.	230. 010 too	_/	Probably 4 Unknown		
	(1) Supticem	na conth	Stapley	106cms	Pridem	ides	2.0110 00.	Tobbony 4 Bonkinown		
Completed by P	2) ASPITATION	on freumo	mtis a	in Methic Drithery So Ococo	(Nin Nesist Tract in 1967 Actus	24a. Was an performs		Were eutopsy findings eveilabla prior to completion of cause of death?		
Com	5) Pamcecut	itis @ Di	Wholes A	nellitus (1)	Anema	1 Yes	2 2 No	1□Yes 2□No		
To Be	25. Wes case referred to medic examiner?	al Hospital:			Other	eath (Check only one,				
	1 Yes 2⊠ No	1143 Ing		Outpatient 3 DOA	4 Li Nursing	Home 5 Residen		ecify)		
Certification:	27. Mengrer of Death t Maturel 5 Pend 2 Accident inves	ing (Month,	Dey Year)	Time of 28c. Injury M	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe hov	v injury occurred			
THE	3 ☐ Suicide 6 ☐ Could deter	mined 286. Pleca o	f Injury - At home, , etc. (Specify)	farm, street, factory, of	fice	28f. Location (Stre City or Town,	eet and Number or F Stete)	Rurel Route Number,		
edical Ce	(Check only 2 Medica	ing Physician: To the be	is of examination e							
Mec	29b. Signeture, and title of certifi	one) end manner steted. 9b. Signeture and title of certifier 29d. Date signad (Month, Dey, Year)								
)	Moramy	ned A.M.	mman	MAN) D	2459	5	9.23	, 60,		
1	30. Nema end address of person	who completed cause	of death (hem 238	Type Print) 2	331- T	OLEDO	TERLIA	ER 20782.		
State	31. Date filed (Month, Day, Year	r) / 32. Red	gistrer's Signeture	, ,	1777 /	DVILLE	1 1.(1)	10010		



		1. Decedent's Nar	ma (Firet Mid	dle Lest)		08	rtificate o	Death		2. Data of Dea	Reg. No.		3. Time of Death	
Physici	ian	1. Decedent's Nam								Month Sept 24	Dev	Yaer		
/Medi		-		Lbert Boe		_		4h City To		cation of Death		of Death	5:30 AM	
Examir	ner			ooke Nurs						ring,				
		5. Sociel Security	-	6. Sex	7. Aga (In yrs.		If Undar 1 Yas			8. Dete of Birth (Month, Day	Monto		4	
uneral irector		477 16	1870	1∏M 2□ F		Yrs.	Months Day	s Hours				Minn.	leca (Stata or Fora etry)	
		Usuei Residance	1							Sept 23	7 1922			
ehow ad at	_	10a. Sieta	10b. Count	ly		ty, Town or Lo						10	0d. Inside City Lim	
or 28a-f	octo	MD		ntgomery	5.	ilver	-						1 ☐ Yes 2 ☐	
0	급	10e. Street end N	Glenea	agles D	rive		10f. Zip Code				10g. Citizen of What Country			
Items 23a	Funeral Director	11. Meritel Stetus			ecedent Evar in U	IS 13	20906 Wes Decedani of		lain? (Sne	cify Ves or No-	United States			
The T	E	1 Never Me		Armed	Forcas?	TT	If Yes, specify Cuben, Maxican, Puarto Rican, etc.)			Rican, etc.)		ck, White,		
be filed within 72 hours effer deeth with the Meryland Hygiane. d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at		XX Widowed		if Yes, Yaar o	s 2 □ No [√]√] Giva r Dates:	11	1□ Yas 🏋 N	o Specify.	:		Specify	·· V	Mite	
lea l	Completed	/Cm	15. Decede	ni's Education	et.	16a. Dece	deni's Usual Occ	upation	at of workin		16b. Kind of Bu	usiness/ind	dustry	
Med	nple	Elamantary/Sec		ast grada complete College	e (1-4or 5+)	life.	DO NOT usa reti	red)	SI OF WORKS	'9				
4	Co		12	3		Acco	untant	Lance	11.1				rice Comm	
ie marked other than "natural", summitic event, the Medical Exa	Be	17. Fethar's Nema									Maidan Surnar	na)		
Tark	2	Theodore				405 54-10	Add (Cha-			tta Doe		0.4. 70	0.11	
7 le r traur				nship <i>(Type, Print)</i> ni (DAUGE	(प्राचाप		7 Pools						•	
Department of Health and Merimportant: If Item 27 ie marke any injury or other traumatic once.		20a. Method of Di		111 (22100)	20b. F	Piace of Dispo	7 Rocky		way,	Dete	Spring 20c. Location -			
				3 Removei fro	m Stete		matory or other p			20				
important: If any injury or once.		4 Donation 5 Other (Specify) Resurrection Cemetery Sept 28, 2000 Clinton 21. Signeture of Funeral Sarvice Licensee 22. Nama and Address of Facility Lee Funeral Home Tro									ton, $^{\mathbb{N}}$	Maryland		
Depar impor any ir		21. Signeture of Funarel Sarvice Licensee 22. Nama and Address of Facility Lee Funeral Home, Inc Alexandria Ferry Road, Clinton, Maryla										TUC 0	9 3072E	
		23a. Part1. Enter	the diseasa,	or complications the	at caused tha deat							Lylan	Approximeta	
Physician		snock, or ne	en tellure. Lis	st only ona ceusa o			,					į	Onset and Death	
dical		Immediete Ceuse disaase or condit	Finel	K	Due to (c	Fei	lure					i	>140	
kaminer		resulting in deeth)	a			•							
	luer	4.15			Due to (c	or es a conse	quence of):					i		
HS.	lue l			- h	YP +	cas;	quence of):							
and -transit	xamine	Sequentieity list of	conditions,	C b. H	ype-t	Casion es e conse	יים יי							
iclan and buriel-transit	al Examiner	Sequentielly list of if eny, leading to cause. Enter Ucause, Oisease of the cause o	conditions, immadiete derlying or Injury	S b	ype-t	ens;	יים יי							
physician and s the buriel-transit	edical Examine	Sequentielly list of eny, leading to cause. Enter Unc Cause (Disease of thet initieted even resulting in deeth)	its	c	ypr- f	ens;	quence of):							
naing prysician and use es the burief-transit	edical	thet initieted even	its	c	ypr- f	Cas; or es e consec	quence of):							
attending for use es	edical	resulting in deeth) Last	c	Due to (c	C45	quence of):	shiven in Dout		Oab Dide				
by the attending physician and ached for use es the buriel-transit	edical	resulting in deeth) Part II. Other sign	nts) Last aificant condit	cd	Due to (c	or as a consecutive as	quence of):	A /						
by the attending tached for use es	Physician/Medical	Part II. Othar sign	Last Last Alficant condit	cd	Due to (co	or as a consecutive for the subting in the subting	quence of): quance of): inderlying cause	fect	ed	101				
gned by the attending se detached for use es	by Physician/Medical	Part II. Othar sign	Last Last Alficant condit	cd	Due to (co	or as a consecutive for the subting in the subting	quence of): quance of): inderlying cause	fect	ed	101	res 2 No an autopsy	3 ☐ Prob	Dably 4□ Unkn	
s been signed by the attending 2 should be detached for use es	by Physician/Medical	Part II. Othar sign	Last Last Alficant condit	cd	Due to (co	or as a consecutive for the subting in the subting	quence of): quance of): inderlying cause	fect	ed	101	/es 2⊠No	3 Prob	Dably 4 Unknown	
hes been signed by the attending ge 2 should be detached for use es	by Physician/Medical	Part II. Othar sign	Last Last Alficant condit	cd	Due to (co	or as a consecutive for the subting in the subting	quence of): quance of): inderlying cause	fect	ed	101	an autopsymed?	3 Prob	bebly 4 Unknown under autopsy finding eilable prior to mpletion of causa	
ate hes been signed by the attending page 2 should be detached for use es	Completed by Physician/Medical	Part II. Other sign Ve- f D; o/y 25. Wes case refe	is Last Last Peb-c Sis Ac Le	d	Due to (co	or as a consecutive for the subting in the subting	quence of): quance of): inderlying cause	fect	ed	24e. Wes a perior	an autopsymed?	3 Prob	ere autopsy finding eilable prior to impletion of causa daeth?	
is certificate hes been signed by the attending director, page 2 should be detached for use es	by Physician/Medical	Part II. Other sign Ve- f D; a/y Strong	its Last its conditions conditio	d	Due to (co	or as a consecutive for the subting in the subting	quence of): quance of): quance of): print 3 DOA	26. Pleco	e of Deeth	24e. Wes a perior	an autopsymed?	24b. We eve cor of c	ere autopsy finding silable prior to mpletion of causa daeth?	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** Booker 2000 treda /Medical 4b. City. Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Cross Silver Spring Itospital mont. Il Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Min. 1□M 2 F 6998 80 Yrs. Director Ala. Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Yes 2 No MD Director mont. 10e. Sfreet and Number 10g. Citizen of What Country? Creek PKW USA 14. Race - American Indian, Bleck, White, etc. or Herna 11. Meritel Status filed within 72 hours after 1 Never Married 2 Married 1□Yes 2XNo ρ 3 Widowed 4 □ Divorced Black Be Completed 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Beautician 12 Yrs 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden is marked of Department of Health end Mental important if Item 27 is marked or John Kainer Jos ephine moore 19b. Mailing Address (Street end Number or Aurel Routa Number, City or Town, State, Zip Co. 3)03/8 19e. Informant's Neme/Reletionship (Type, Print) Nephan Edward Aline Atlanta 26b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete Burial 2 Cremetion 3 Removel from State George Wash. Cem. 9-28-00 Adelphi, MD 4 ☐ Donetion 5 ☐ Other (Specity) 22. Name end Address of Fecility John T. Rhines Company 3015-12th St. NE Wash DC 2001 23a Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, book, or haart failura. List only ona causa on aach lina. **Physician** fmmediate Causa (Finel disease or condition rasulting in death) /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lesf Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Wara eutopsy findings evailable prior to completion of ceuse of death? 24a. Was en autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 267 No 25. Was case referred to medical 26. Placa of Death (Check only one) Hospitel: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 AND edical Certification: To 1 Impatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1/ Natural
2 Accident

Box 68760, P.O. of Vital Records, or Attending Physicien: Division Hospital 24 hours a Funerel D

Baltimore, Maryland 21215-0020

after death Director:

29a. Certifier

3 Suicide

4 Homicide

6 Could not be

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License pumber

1 Yes 2 No

29d Days signed (Month, Day, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

31. Date filed (Month, Day, Year)

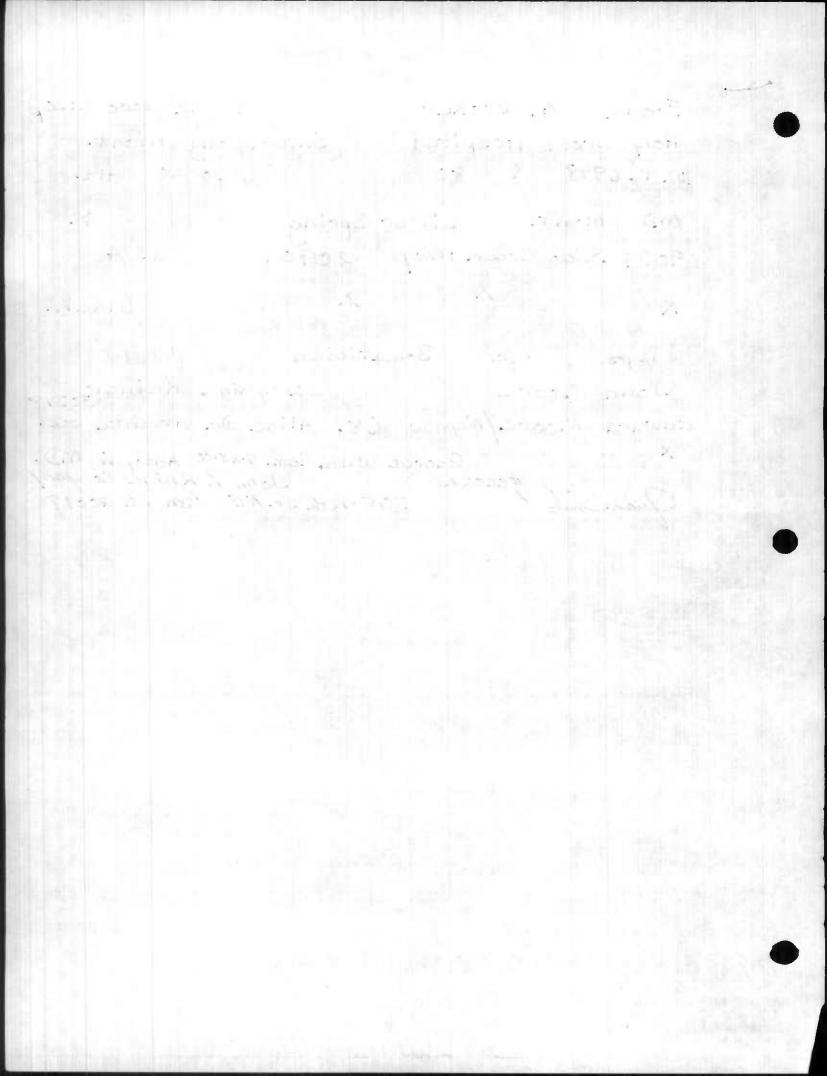
32. Registrar's Signature

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Registrar **DHMH 16 Rev 6/95**

State

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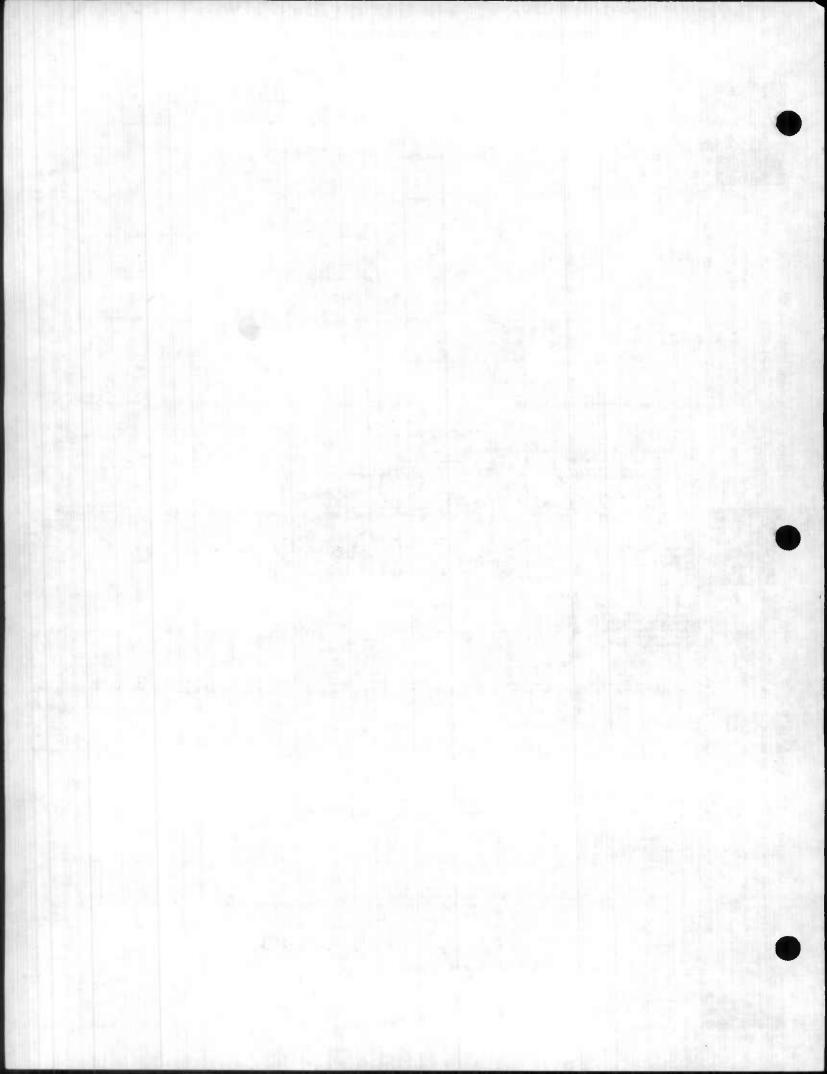
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death S'EPT **Physician** SOLDE 1052 anomyA. 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner BACTIMORE 102 PI PAI -13F If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth | Month, Day. Year). | June 17, 1952 7. Age (In yrs. last birthday) 6 Sev 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1⊠M 2□ F 48 Months Virginia Yrs. 231-78-5598 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Haalth and Mental Hyglena. Important: if item 27 is marked other than "natural", or items 23a or 28s-4 show any Injury or other traumatic event, the Wedest Extract. Frust by notified at educa. 28a-f ahow Virginia 1 Yes 2 □ No Richmond Directo 10f Zip Code 10e. Street and Number 10g. Citizen of What Country? 23220 United States 1923 Lakeview Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Raca - American Indian, Black, White, etc. 1 Never Married 2€ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Baggage Handler Greyhound Bus Co. 11th 18 Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Raymond Anderson Blanche Ellis 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rose Anderson/Sistwer 1106 Apt. D. Dove St. Richmond, Va. 23222 20b. Place of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10/4/00 Roselawn Mem. Garden Richmond, Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one-cause on each line. 20747 Approximate Intervat Between Onset and Death **Physician** fférentiated CARCINOMA 4 Months Immediate Cause (Final disease or condition resulting in death) /Medical Examiner to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed for usa as the bunai-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequenca of) Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of) P.O. 23b. Did tobacco use contributa to the cause of death? Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by should be datach 1 Yee 2 No 3 Probably 4 Striknown Division of Vital Records. þ ata has been si page 2 should 24e. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of deeth? 1 Yes 30 No 1 ☐ Yes 2 ☐ No this certificata or Attanding Physician: 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA Certification: 27. Menner of Deeth 28d. Describe how Injury occurred fnjury at Work? aftar death.

I Director: Aftar tild in by the funara 1 Natural 2 Accident 5 Panding investigation 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours a To the Funeral C compiataly filled To the Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and pleca, and due to the cause(s) and manner stated. edical 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) PAUL PLACE BACTIMIZE NO 21202 DSEPH SEP 2 8 2000 32. Registrar's Signeture State

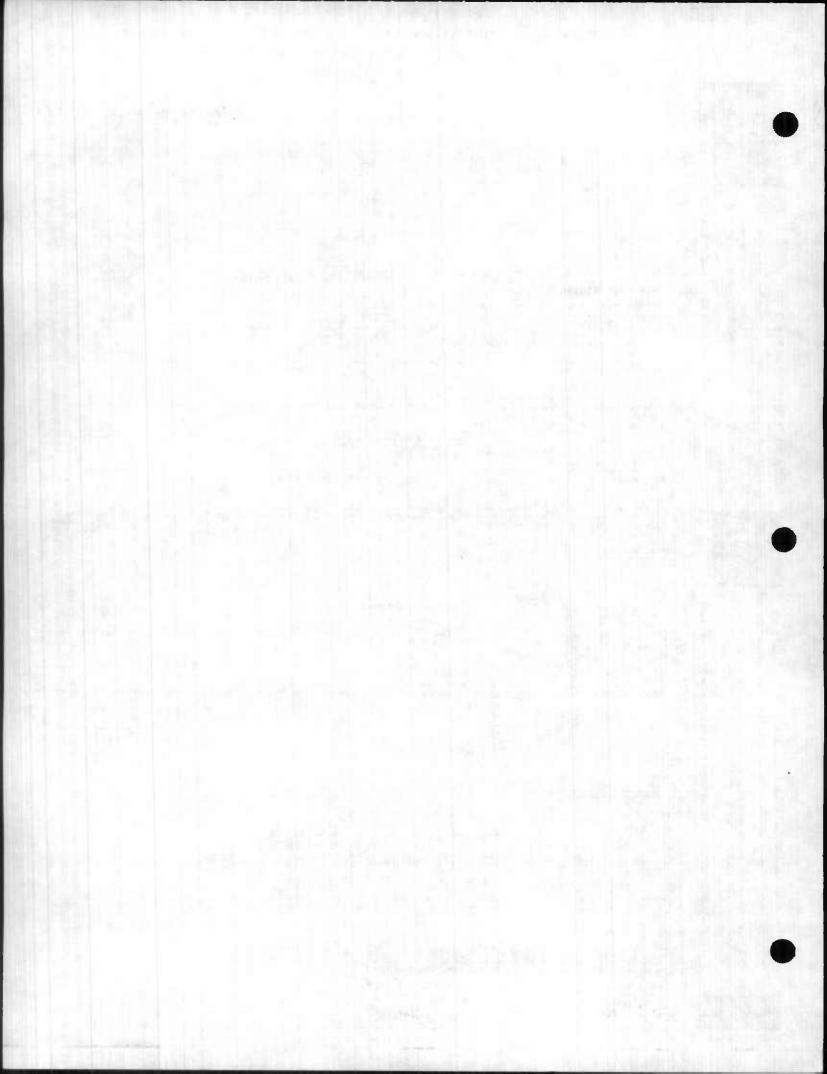
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 0 0 32208

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Physician /Medical	_	Delores Edmonia	a Border	rs						Septembe	,	2000	3:2	7 PM
/Medical Examiner	4.0	Facility Neme (If not institution, give	street end nun	nber)				4b. City, To	own, or Lo	cation of Death	4c. County	- Made - Marie		
	п	Doctors Hospita	1					La	nham		Prin	ice G	eorge's	5
uneral	5.	Social Security Number 6. Se	ex .	7. Age (In yrs.	last birthday	If Unda				8. Dete of Birth (Month, Dey,	Voor	9. Birthpl	leca (Stete or i	Foreign
ector		578-58-9448	□M 217 F	6	1 Yrs.	Months	Deys	Hours	Min.	Mar. 30	, 1939		h., D.(
- 17	-	suel Residence of Decedent												
or forms 234 or 284-1 show		0a. Stete 10b. County		10c. Ci	ty, Town or L	ocation						10	0d. Inside City	
oto	M	Maryland Prince O	George's	3		Gre	enb	elt					1 DYas 2	2 LI No
Director	10	De. Street and Number				10f. Zig	Code			10	g. Citizen of V	Whet Coun	try?	
ai		6205 Springhill	Drive	#201		51 Be		207	70		United States			
Funeral	1	1. Marital Status	12. Wes Dece		J,S. 13.	Wes Dece	dent of	Hispanic Or	igin? (Spe	igin? (Specify Yas or No- n, Puerto Rican, etc.)		14. Race - American Indian, Bleck, White, etc.		
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Completed		15. Decedent's Edu (Specify only highast grad	ucation		16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)					6b. Kind of Bu	usiness/Ind	Justry		
apple		Elementery/Secondary (0-12)	College (1	4or 5+)	life.									
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Be		7. Fathar's Name (First, Middla, Last)						18. Moth	er's Neme	(First, Middle, N	feiden Sumen	10)		
10		Adolph Trent							Hat	tie Dad	9.			
		9e. Informent's Name/Reletionship (7,	ype, Print)	0 9 4 4	19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code)						Code)			
		Anthony Littleford - Son 1122 Elfin Ave., Capitol Heights, M									ID 20	0743		
	20	Da. Method of Disposition			Plece of Disp	osition (Ne	ne of	ece)		Dete	20c. Location -	City or To	wn, Stete	
any Injury or		1\(\text{Burial}\) 2\(\text{Cremetion}\) 3\(\text{Removel from State}\) Cedar Hill Cemetery 9/30/2000 Suitland, MD												
	2	4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Addrass of Facility Stewart Funeral Home												
	18	1 - 6	4	AT	T				. 0					
		23a Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, and tailure. List only one cause on each line. Approximate interval Betw.												
		shock or heart failure. List only o	one cause on e	sch line.	th. Do not el	ntar tha mot	at or dy	ring, such es	cardiec c	or respiratory arre	151,	1	Interval Betwee	
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Ah		Hypertension	2							1 Y	0 20 No	3 ☐ Prot	bably 4 🗆 U	Inknown
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-	-	7. Menner of Death			28b. Time		JA	4 🗆 14		28d. Describe ho			77	
ertification:		1.☑Neturel 5 ☐ Pending		f Injury h, Dey Year)	Injury	м	28c. Inj W 1 [ork? □Yes 2□					J	
Ca		3 Suicide 6 Could not be		of Injury - At I	ome form s					28f. Location (St.	raet end Numt	ber or Rura	I Route Numb	er.
ŧ		4 ☐ Homicide determined	buildir	ig, etc. (Speci	ify)	treet, lactor	y, onici			City or Town	, Stete)	or or riara		.,
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edicai	2	9a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exam	iner: On the ba	sis of examine										
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Σ	2	9b. Signeture and title of certifier						nsa number	er:		9d. Date signe			
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	30	0. Nema and address of person who c	ompleted cause	e of deeth (Ite	m 23e) (Type	e, Print)		UJE				_		
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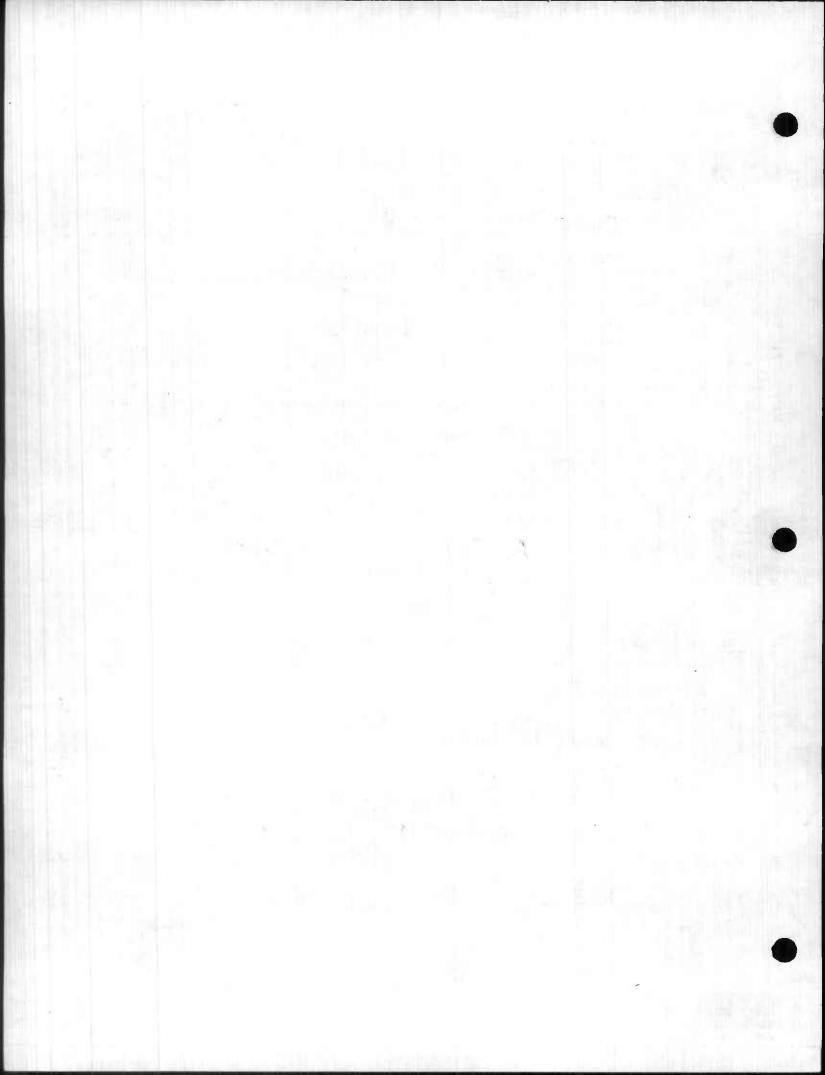
DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 2 0 9

	Certific	ate of Death	Reg. i	No.								
	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death							
Physician	Celestina Blackellar		Sept. 25	, 2000 Year	8:00AM							
/Medical Examiner	4a Facility Name (If not institution, give street end number)	4b. City, Town, or		4c. County of Death								
Examine	Washington Adventist	Takoma Pa		Prince Geo								
Funeral Director	5. Social Security Number 6. Sex 1 M 2 X F 7. Age (In yrs. last birthday) Mont 4 Mont 578-06-8949 Usual Residence of Decedent		8. Date of Birth (Month, Day, Yes	er) Coun	lace (Stete or Foreign try) aica							
1	10a. State 10b. County 10c. City, Town or Location			11	0d. Inside City Limits							
tor ctor	MD Prince Georges Hyattsville	AT ME			1 □XYes 2 □ No							
23a or 2 at being	10e. Street end Number 10f. 5815 Maryhurst Dr.	Zip Code 20782	10g.	10g. Citizen of What Country? USA								
natural, or frame 23a or 28a-f show ideal Examine must be notified at eted by Funeral Director	1 Never Merried 2 Married 1 Yes 2 No	cedent of Hispanic Origin? (S specify Cuban, Mexican, Puert S 2 No Specify:	pecify Yes or No- to Rican, etc.)	city Yes or No- Rican, etc.) 14. Race - America Bleck, White, e								
"natural", designation	15. Decedent's Education 16a. Decedent's United to 16a. Decedent United to 16a. Decedent United to 16a. Decedent United to 16a. Decedent United to 16a. Decedent United to 16a. Decedent United to 16a. Decedent United to 16a. Decedent United to 16a. Decedent United to 16a. Decedent United to 16a. Decedent United to 16a. Decedent United to 16a. Decedent United to 16a. Decedent United to 16a. Decedent United to 16a. Decedent United to 16a. Decedent United to 1	isual Occupation	16b.	. Kind of Business/Ind	dustry							
	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homema	work done during most of wor Fuse retired) ker	A.4-	omestic								
Hygie Co	17. Fether's Name (First, Middle, Last)		me (First, Middle, Maid									
e sver	James Scott	Wilhem										
market umatica				ty or Town State Zin	Code)							
aalth an n 27 is er trau		lailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5 Maryhurst Dr., Hyattsville, MD 20782										
Department of Health and Mental Hygiena. Important: If Item 27 is marked other than any Injury or other treumatic avent, the Mades. To Be Compi	20a. Method of Disposition 1 DXBurial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Dother (Specify) 20b. Place of Disposition (Name of cametery, cremetory or other place) Rockcreek Cemetery Sep 30, 00 Washington,											
Departrumental importal any injuries.	21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility Johnson & Jenkins Funeral Home 716 Kennedy St., NW Washington, DC 2001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Appropriately and the disease of the disease of the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Interval.											
nysician Medical xaminer	Immediate Ceuse (Finel disease or condition resulting in death) a. ACUTE RESPINATION Due to (or es a consequence	fory Fai	lure	1	Onset end Death							
e attanding physician and od for usa as the burial-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last b. Due to (or es a consequence of the consequen	of):		1								
ed for	Pert II. Other significant conditions contributing to death but not resulting in the underlying	g ceuse given in Part I.	23b. Did tobac	cco use contribute to	the cause of death							
igned by the attendibe datached for us:	SEPSIS		1 🗆 Yes	2□ No 3□ Prot	bably Unknow							
been s should	Acute Renal Failure		24a. Wes en eu performed	1? ave	ere autopsy findings eilable prior to mpletion of cause death?							
s cartificata has director, paga 2 To Be Comp	Pailure to 1 horve	30.71	1 ☐ Yes		Yes 20 No							
cartificata irector, pag	25. Was case referred to medical examiner?		ath (Check only one)									
this cartific			tome 5 Residence		y)							
a ta	27. Manper of Death Natural 5 Pending investigation 3 Suicide 4 Homicide	1 ☐ Yes 2 ☐ No										
within 24 hours after death. To the Funeral Director: A complataly filled in by tha fi Medical Certificati												
To the comple	one marities distress.	29c. License number 29d. Date signed (i										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	NO , was	hington.	DC 701	010							
State	31. Dete filed (Month, Day, Year) 32. Registrar's Signature		•									



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev **Physician** Month BENNETT MAYFIELD SCPTEMBOL 76, 2000 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner MANOR CARE HEALTH SILVER SPRING 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Wooth, Day, Year) 4/13/04 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Deys Hours 10 M 20 F NEW LONDON, NC 96 Yrs. 240-46-8236 Director Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28a-f ehor Examiner must be notified at DC N/A WASHINGTON Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20017 635 EDGEWOOD ST NE #227 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Alo If Yes, Give Year or Datas: Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married "naturel", or 1□ Yes 2□ No þ Specify: BLACK 3 Widowed 4 Divorced Completed th end Mentel Hygiene.
7 is marked other than "natur treumatic event, the Medical 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 8TH GRADE NONE HOMEMAKER OWN HOME Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) . Pages 1 end 2 should be file ment of Health end Mentel Hy lant: if Item 27 is marked oth lury or other treumatic even Be SAMUEL J. WALKER KEARNS 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) CLARENCE RICE (GRANDSON) 6622 7TH PLACE NW, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State permit. Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) GLENWOOD CEMETERY 9-30-00 WASHINGTON, D.C. 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Fecility JOHN T. RHINES CO., INC. Small to 3030 12TH ST NE, DC 20017 23a. Pert1. Entar the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haert failure. List only one cause on each line. Approximete Interval Between Onsat end Deeth **Physician** Immediata Ceuse (Finel disease or condition rasulting in death) /Medical Due to (or es e consequence of): ACUTE Examiner Examiner CORONOMY Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceusa (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) STPERTENSION Physician/Medicai Due to (or es e consequence of) Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown CEREBROVOSCULAR ACCIDENT g 24b. Ware autopsy findings eveileble prior to complation of cause of daeth? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 🞾 No Physician: Be 25. Was case referred to madical 26. Piece of Daath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this 28e. Deta of Injury (Month, Day Year) 27. Menner of Deeth Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Hospital or Attending 5 Pending Investigation 1 Naturel s efter death. 1 Yes 2 No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, straet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide To the Hospital of within 24 hours of To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end mannar as stated.
 2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, dete end plece, end due to the cause(s) and menner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25422 JEPTEMBER 27, 2000 30. Nema and eddrass of parson who complated cause of deeth (Itam 23a) (Type, Print)

State Registrar

ROBERT MASSIN, MD 32. Registrer's Signature

Louke

13952 BOLTIMORE AVE, LAUREL, MARYLING 20707

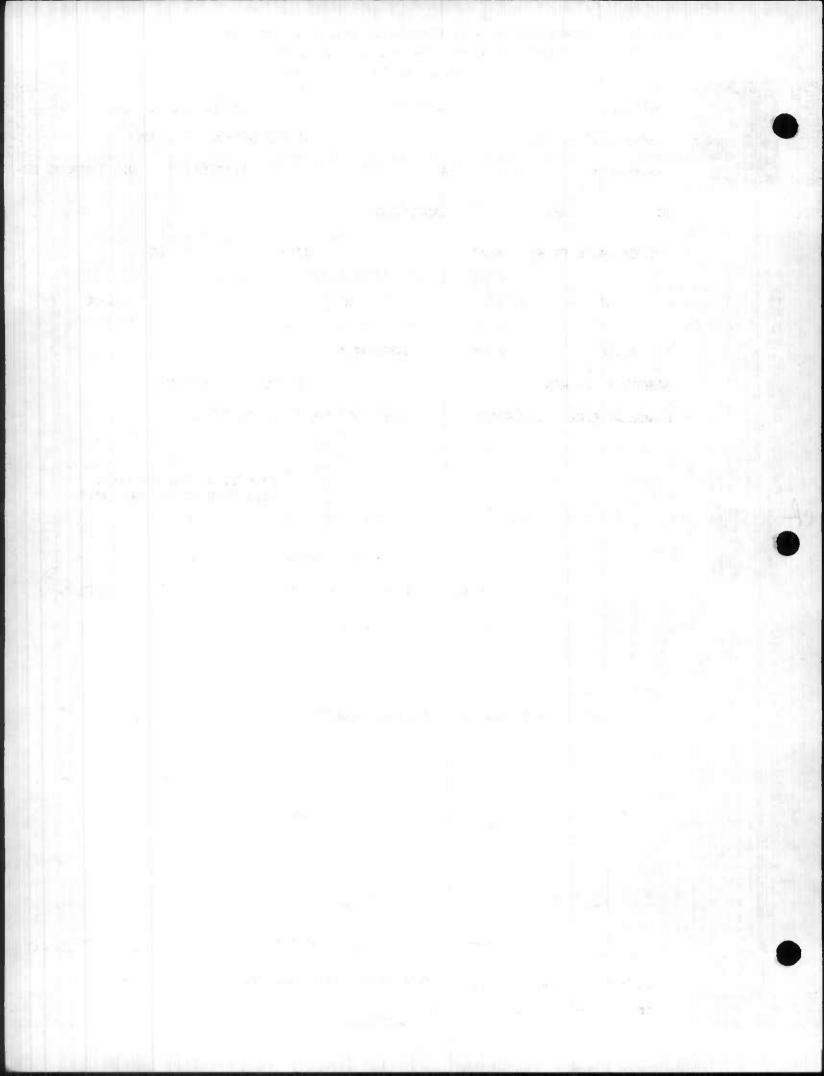
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P.O. Box 68760.

Records.

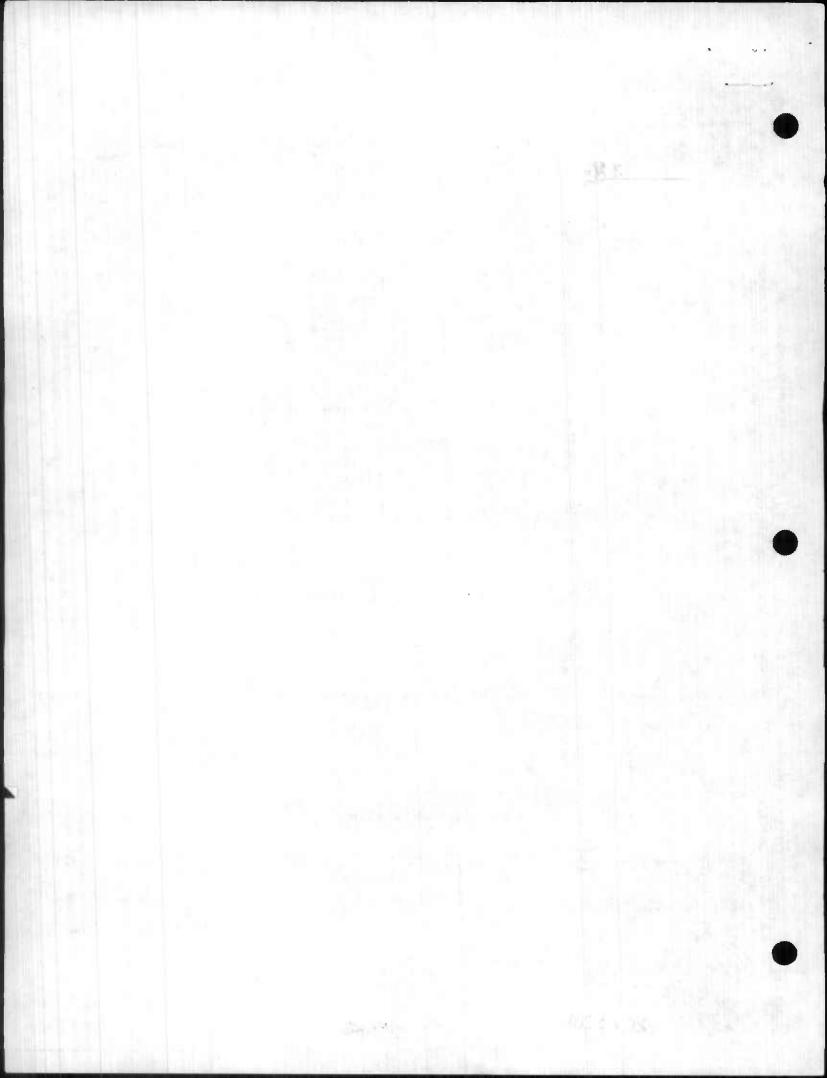
of Vital

Division



AM	ENDED # 5.	P.G. GC, 9/27/00 ame	State of Maryland and item 2 per md G7				ene 🔾 🔾 og. No.	06611						
	Physician /Medical	Decedent's Name (First, Middle, La David Emory				2. Dete of Death Month Septemb		year 2000 12:20 am						
	Examiner	4a Facility Name (If not institution, give	re street end number)		4b. City, Town, or Le	ocation of Deeth	4c. County of	of Death						
		Washington Adve	entist Hospital		Takoma Pa	ark	Mont	gomery						
	Funeral Director		Sex 7. Age (In yrs. las 1 ☑ M 2 ☐ F 91	t birthdey) If Under 1 Yrs. Months I	Yeer If Under 24 Hrs. Deys Hours Min.	8. Date of Birth (Month, Day, May 7,	Year) 909	9. Birthplace (Stete or Foreign Country) Maryland						
	2 ,	Usuel Residence of Decedent	100 City	Town or Location				10d Incide City I Imite						
	ahov ahov	10e. State 10b. County						10d. Inside City Limits 1 ☑ Yes 2 ☐ No						
	vith the Mer or 28a-f al be notified Director	Maryland Prince	George's F	Riverdale	-4-	14	og. Citizen of W							
	Die Por		T * . 1											
	ma 23	4409 East West I	11gnway 12. Was Decedent Ever in U.S.		20737	ecify Ves or No-	U.S.A.	- American Indien,						
020	within 72 hours after deeth with the Meryland see. Then 'naturat', or items 23s or 28s-f show the Medical Examiner must be notified at the Medical Examiner must be notified at the Medical Examiner must be notified at	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify 1 ☐ Yes 2 🖔	nt of Hispenic Origin? (Sp. Cuban, Mexicen, Puerto Discourse) No Specify:	Rican, etc.)		k, White, etc.						
21215-0020	ed within 72 hours aff vgiene. er than "naturat", or ft, the Medical Exam Completed by F	15. Decedent's E (Specify only highest gra	ducation ade completed)	16e. Decedent's Usual ((Give kind of work)	done during most of work	ing	siness/Industry							
121	yiene.	Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use										
es .	_ = . = 0	17. Fether's Neme (First, Middle, Last	1	Piano Tead	18. Mother's Nam	e (First Middle N		mployed						
<u> </u>	Mental Hyg srked other stic event, To Be C													
7	d 2 should th end Men 7 is marke traumatic	Robert Emmett 19a, informant's Neme/Relationship	Brennan	10h Mailine Address /	Ethel Streat and Number or Rur	Corinne	Reese	State Zin Code)						
Z a	0 0 0 0	Lawrence E. Bren			Ridge Drive									
0	1 and Health em 27 Ither tr	20e. Method of Disposition	20b. Plac	e of Disposition (Neme	of		0	City or Town, State						
Baltimore	5 4 2 0	1 Buriel 2 Cremation 3 D	Removal from State	netery, crematory or other	er plece)									
= 1	pemit. Pege Department of Important: If any injury of price.	4 □ Donation 5 □ Other (Special		coplitan Cr		9/23/2000	Alexan	dria, Virginia						
Ba	Buch in the	> 7-lenn D	22. Name end Address of Fecility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781											
		23a. Part 1. Enter the disease, or com shock, or heart ladium. List only	plications thet ceused the death. one cause on each line.	Do not enter the mode of	of dying, such as cerdiac	or respiretory erre	est,	Approximate Intervel Between Onset end Death						
	Physician /Medical Examiner	Immediate Ceuse (Final disease or condition	. SEPSIS											
ш.		resulting in death)		s e consequence of):				~ I day						
	sit sit		ASPIRAS	TON P	NEUMON	A		~ I day						
	hysician end the bunal-transit dical Examiner	Sequentially list conditions, if any leading to immediate	Due to (or e	s e consequence of):										
68760,		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that in the least of the cause)	C											
	phys the	that initiated events Due to (or es e consequence of):												
×	nding puse as		d											
Вох	attending p for use as		Mark Comment											
P.O.	ysi ysi	Part II. Other significant conditions	contributing to death but not resulti	ng in the underlying cau	se given in Pert I.			tribute to the cause of death?						
0	es that the igned by be detacted by Phy					1 1	8 2/4 NO	3 Probably 4 Unknown						
of Vital Records,	been s should					24a. Wes as perform		24b. Were eutopsy findings available prior to completion of ceuse of death?						
E .	0 - 5 -					1□ Ye	s 200 No	1 ☐ Yes 2 ☐ No						
ta	certificate he rector, page	25. Wes case referred to medical			26. Place of Deel	th (Check only on	e)							
>	Physician: this certific ral director,	examiner? 1 ☐ Yes 2 ② No	Hospital: 1 Inpatient 2 EF	R/Outpatient 3 DOA	Other:	ome 5 Reside		ar (Specify)						
	erthi eral	27. Manner of Death			: Injury et Work?	28d. Describe ho								
0	Attending or death. ector: After by the fune iffication	1 Alatural 5 Pending investigation		M	1 Yes 2 No									
-	T	3 Suicide 6 Could not be determined	28e. Plece of Injury - At hom building, etc. (Specify)	e, farm, street, factory, o	office	28f. Location (St. City or Town		er or Rural Route Number,						
	within 24 hours at To the Funeral Di Completely filled li	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)			nner es stated. and due to the cause(s)									
	Ne the	29b. Signature end title of certifier			icense number			(Month, Dey, Year)						
		M.S-M	oyar		0-1787	4	Septem	ber 22, 2000						
	4)	30. Name and address of person who SANKARAW M												
	State Registrar	31. Dete filed (Month, Day, Year)	32. Registrer's Signetur	re				And the state of t						
	ricgistiai	SEP 2 5 2000	San San San San San San San San San San	1. 2220 1	. /									

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 2 2 | 2

State of Maryland /	Department of Health and Mental Hygiene	1

					Certificate of	Death	R	eg. No.		trop Sony I had			
	Physician	1. Decedent's Name (First, Middle, L SHELIA ANN					2. Dete of Deal Month SEPTEMB	th Day	Year 2000	3. Time of Death 7:25AM			
	/Medical	4a Facility Neme (If not institution, g	ive street and number)			4b. City, Town, or	Location of Death	4c. County		7:23AM			
N.	Examiner	National Inst			h	Bethes		Mont		rv			
ı	Funeral	5. Sociel Security Number 6.	Sex 7. Ag	e (In yrs. last bit	thday) If Under 1 Year	If Under 24 Hrs	8. Date of Birth (Month, Day)	Veer		ece (State or Foreign try)			
	Director	558-49-7441 Usuel Residence of Decedent	1 M 20 F	38	Yrs. Months Days	Hours Min	Oct. 9	1961		owa			
	show	10a. Slete South		10c. City, Tow	n or Location				10	Od. Inside City Limits			
	with the Maryland ta or 28s-f show the notified at	Carolina Greer 10e. Street end Number P. O. Boy 614	ville	Gr	eenville					1 GYes 2 No			
	or 26	10e. Street end Number			10f. Zip Code		1	0g. Citizen of V	Vhat Count	ry?			
	death w	P. O. Box 614			2960			U.S.					
	flar death v	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decedent of I	Hispanic Origin? (S ean, Mexican, Puer	Specify Yes or No- to Rican, etc.)		e - America k, White, e				
20	8 0 5		1 ☐ Yes 2√2 If Yes, Give Year or Dates:	No	1□ Yes 2₽ No	Specify:		Specify	Whi	ite			
5-0020	"natural",	15. Decedent's f	Education	16a	Decedent's Usuel Occu		16b. Kind of Bu	siness/Ind	ustry				
215	ed within 72 hor yglana. ner than "natura nt, the Medical Is Completed	(Specify only highest g	rade completed) College (1-4or t	5+)	(Give kind of work done during most of work life. DO NOT use retired)		orking						
21	od withir glana.	12th			Owner/President		New L:			ervices			
pu	tal Hygin of other and oth		it)			18. Mother's Na	me (First, Middle, I	Ma <i>ide</i> n Sumam	θ)				
Maryland	Men Men To	Paul Bernard				-	ınknown)						
Mar	2 sh and Is m	19e. Informent's Name/Relationship			. Mailing Address (Street								
80	f Health fam 27 other t	Ann Brieske -	Mother		267 Datura f Disposition (Name of	Street		erson,		89014			
Jor	S = S	20a. Method of Disposition 1 Darial 2 Cremation 3		cem ete	ry, crematory or other pla								
Baltimore	C partmen C partmen Important: any injury	4 Donetion 5 Other (Spec		Mad	ckey Mortu		9/25/00	Gree	envi.	lle, S.C.			
Ba	C partm C partm Importar any Injur	21. Signature of Funeral Service Lice	22. Name and Address of Facility Marshall's Funeral Home, Inc.										
92		23a. Part1. Enter the disease, or conshock or leart failure. List only	1/aushal	d the death De	4217 8th	Street	N.W.,	Washi	ngtor	n, DC2001			
	Discontinue	shock or heart failure. List onl	y one cause on each li	ne.	not enter the mode or dy	ing, such as cardie	to or respiratory en	631,		Interval Between Onset end Deeth			
	Physician /Medical	Immediate Cause (Finel	Anu	- D.	a American	0 1		1					
	Examiner	disease or condition resulting in deeth)	e. /700	Due to for as a	Consequence of):	1/ISTICE	iss sync	arome	, ,	NOOK			
	<u> </u>		MA	A ST N-13	SPIRATURY consequence of): C ANGIO	SARCOM	14		1	MONTH			
	physician and sthe burial-transit	Sequentially list conditions,			10.14								
90,	cian a												
68760	rificete be execung physician and es the burial-trainer.	that initiated events resulting in death) Lest											
	500		d						1				
Вох	death of atten												
0	tha de sy the sched	Pert II. Other significant conditions	contributing to death b	ut not resulting i	n the underlying cause gi	iven in Part I.				the cause of death?			
0	that hed by dete						1 Y	es 2⊟No	3 L P100	pably 4 Unknown			
Records,							24a. Was a	in eutopsy	24b. We	ere autopsy findings ellable prior to			
00	The law requir pate hes been single page 2 should						perfor	med?	con	mpletion of cause death?			
Re	Tha law sata hes paga 2						127	es 2 No	10	Yes 25 No			
Vital	cartificata rector, pag	25. Wes case referred to medical				26. Place of De	eath (Check only or						
	Z o D	examiner? 1 Yes 2 No	Hospital:	ent 2 ER/O	utpatient 3 DOA Ot	hor-	Home 5 Resid		er (Specify	1)			
n of	g Physical dispersed dispe		28e. Dete of Inju	iry 28b.	Time of 28c. Injury Wo	iry et ork?	28d. Describe h	ow Injury occur	red				
Siol	Attanding Phir death. octor: After the by the funeral iffication:	2 Accident Investigati	on			Yes 2 No							
Division	tal or Attanding Prs after death. al Director: After tied in by the funera	3 ☐ Suicide 6 ☐ Could not determine	28e. Plece of In building, et	ury - At home, for c. (Specify)	erm, street, fectory, office		28f. Location (S City or Tow		er or Rura	l Route Number,			
	n 24 hours in 24 hours in Euneral plately filled	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	miner: On the basis o	f examination ar	e, death occurred at the t d/or investigation, in my								
	within 2 To the comple	29b. Signature and title of cyflytter	and manner st	ated.	29c Licen	se number		29d. Date signe	d (Month.	Dav. Year)			
	F 3 F 8		0 9	//			, ,	al-	1	^			
	(10)	190g an	1 mus	na /	MO ME	0578	1	7/2	3/0				
	(0)	30. Name and address of person who	completed cause of c	death (Item 23a)		Rockwi	lle Pike	Bet	hesd	20892 a, MD			
	State	31. Dete filed (Month, Day, Year)	32. Registr	ar's Signature	3000	TOOK VI.		-,					

Market and American and managed for a contract a department of the A NUMBER OF A SECOND POSSIBLE OF A SECOND PROPERTY

USB BS I After this certificate has death.

r than "natural", or items 23s or 28s-f show the Redical Exampler must be notified at

Hygiene.

permit. Pages 1 and 2 should be file.
Department of Heatin and Mentai Hy important: if item 27 is marked other any injury or other traumatic evant.

other

72 hours aftar

Maryland

00

09/22/00

3AYLOR, HERMAN

Medical Certification: To Be Completed

Diractor: After this certification of in by the funaral director, or Attending To the Hospital o within 24 hours af To the Funeral Di completely

25. Was cese referred to medical axaminer?

1 ☐ Yes 2 🔀 No 27. Manner of Death

5 Pending investigation 1 Natural 2 Accident 3 ☐ Suicide 6 Could not be determined 4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29e, Certifier (Check only one)

28a. Date of Injury (Month, Day Year)

eyan chd

28b. Time of 28c. Injury at Work?

Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29c. License number D 50653

1 Yes 2 No

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print) GYAN_C. SURANA Dealechwichton Road Deale mp

31. Data filed (Month, Day, Year)

29b. Signeture and title of certifier

SEP 2 6 2000

32. Registrar's Signature

doorka

Registrar

3

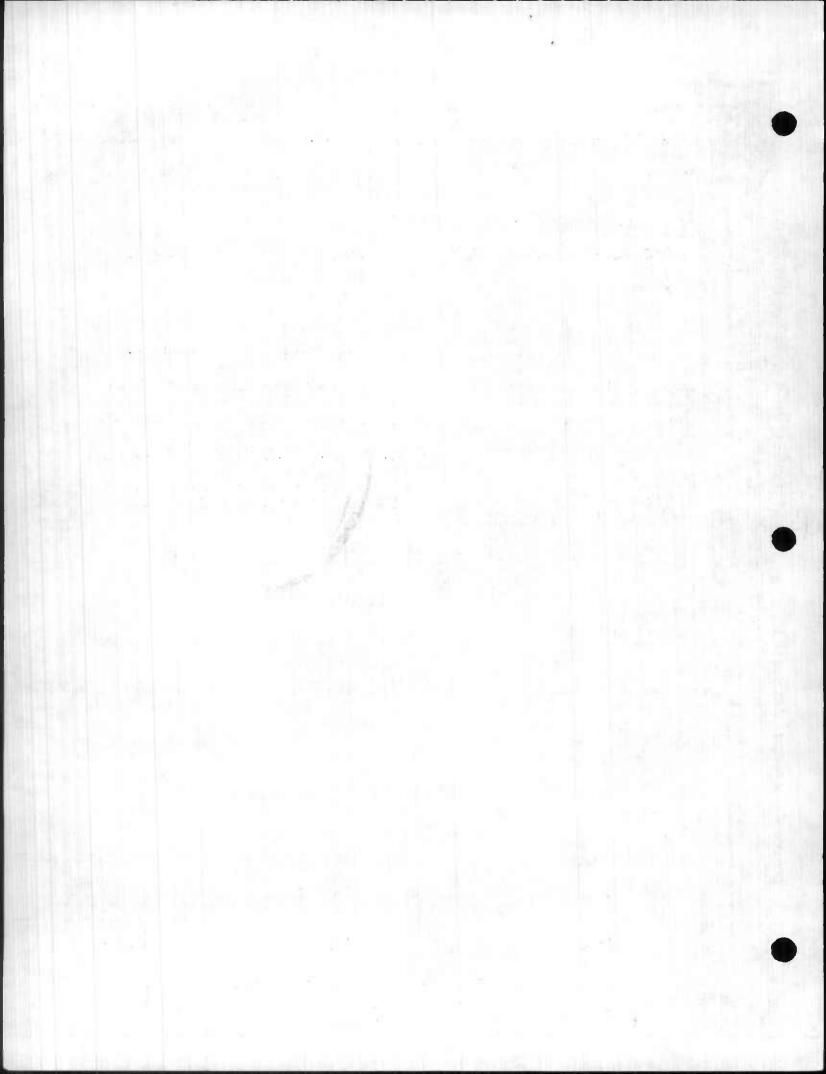
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ARIANNA MICHEILE BUITS 12:35 am 2000 /Medical 4e Fecility Neme (Il not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner PRINCE GEORGES PLINCE GEORGES HOSPITAL CENTER. CHEVERLY If Under 1 Yaar | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F SEPT. 20,2000 Director NONE Usual Residence of Decedent 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flame 23a or 28a-f ahow the Madical Examiner must be notified at 1XYes 2□No MARYAND PRINCE GEORGES Director LANDOUER 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 20785 6812 FLAGSTAFF STREET U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Stetus Bleck, Whita, etc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BI-KACIAL à 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If Hem 27 is marked other than any Injury or other traumette avant Elementery/Secondery (0-12) College (1-4or 5+) NONE-INFANT vone NEWE - INFANT work. 17. Fathar's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be MICHAEL CHRISTOPHER BUTTS ZINATA LASHAUN RICKS 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) 6812 FLAGSTAFF ST. LANDOUER, MU 20185 MICHAEL C. QUITS 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stafa 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Cedar Hill Cemetery 5 Other (Specify) 9/23/2000 Mill Hall, PA. 4 Donetion 21. Signature of Funeral Service Licensee 22. Name end Addrass of Fecility George P. Kalas Funeral Home, P.A. als 6160 Oxon Hill Rd. Oxon hill, Md. 20745 23a. Pert1. En of the disease, or complication shock, or heart failure. List only one cau Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) Extreme Tremahinte Examiner Due to (or es a consequence of) Nonviable Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Ceuse (Diseese or Injury that initieted events rasulting in death) Last Due to (or es e consequence of): pue Box 68760 physicien Physician/Medical Due to (or as e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en autopsy performed? Completed 1 Yes 22 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending invastigetion 1 Neturel deeth. 1 ☐ Yes 2 ☐ No within 24 hours after deeth To the Funeral Director: A completely filled in by the f 2 Accident 6 Could not be 3 Suicide 281. Location (Street end Number or Ruret Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide ð Hospital 29e. Certifier Medical 1🗓 Certifying Physician: To the best of my knowledge, death occurred et the time, dale end pleca, end due to the cause(s) end menner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred of the time, date end pleca, end due to the ceuse(s) and manner stated. within 2 29c. License number 29b. Signatura and title-of-certifier 29d. Data signed (Month, Dey, Year) 026819 00 30. Nema end address of purson who completed cause of death (Item 23a) (Type, Print) ABOUL CHAUDRY MO-3001 HUSPITAL ORIVE, CHEVERLY MO 20783

State Registrar 31. Dete filed (Month, Day, Year)

SFP 2 6 2000

DHMH 16 Rev 6/95

32. Registrar's Signetura



State of Maryland / Department of Health and Mental Hygiene 0 3 2 2 1 5 cared it tem 23a, 27, per ne C788 1014/500 yF Certificate of Death RCGARD Q. BROWNE RTCIARD Q. BROWNE September 25a 200 11:30 P.M. 45. Double of Name of an atthewn, pas street and number of a state benefaty Spotiary September 25a 200 11:30 P.M. RTCIARD Q. BROWNE RTCIARD Q. BROWNE RTCIARD Q. BROWNE RTCIARD Q. BROWNE RTCIARD Q. BROWNE RTCIARD Q. BROWNE RTCIARD Q. BROWNE Spotiary September 25a 200 11:30 P.M. 45. Double of Debath Creater Laurel Beltsville Hospital Laurel	00-5458-033 CJ		Please	Type or Prin	t in Blaci	c Indelible	lnk. As	sure A	II Coples	Are Legil	ble.			
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Physician (Model and Prince Courty County) RICHARD Q. BROWNE Facility Name (first establishop, pive sized and number) Greater Laurel. Bettsville Hospital Fundal Director F	amend ite	em.				Cermicate	UI Dea	uri				3 Time of Dec	ath	
Formal Schmitter Schmitter	Physicia	in							Month	Day				
Greater Laurel Beltsville Hospital Fundal Director Social Security Number 100 Cap 2 - 2-987 100 Cap 2 -							4b. City	. Town, or L	J			11:30 1	r.M.	
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Reference by the property of the process of the property of the process of the pr	Shoul Man	ř	19a. Informant's Name/Ralationship	(Type, Pnint)	19b.	Malling Address (Street and Nu	ımber or Rui	ral Route Numb	er, City or Town,	State, Zip	Code)		
18 Burial 2 Cramation 3 Removal from State George Washington Ceme. 2000 Adelphi, Maryland 22. Name and Addrass of Facility J. B. JENKINS FUNERAL HOME 23. Name and Addrass of Facility J. B. JENKINS FUNERAL HOME 24. Name and Addrass			Rebecca Bryant H	Browne/Wife	91	01 Sherid	lan Co	urt, I	anham,	Marylan	d 207	06		
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Division of Vital Records, To the Hospital or Attending Physici within 24 hours after deeth.

To the Funeral Director: After this ce completely filled in by the funeral directors.

Medical Certification: To

29a. Certifier ((Check on one)

29b. Signat

27. Manner of Death

1 Neturel

2 Accident

3 ☐ Suicide

6 Could not be datarmined 4 Homicida

5 Pending invastigation

28e. Date of Injury (Month, Day Year) 28a. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Dascribe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.

**XMedical Examiner: On the best of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E.

September 27, 2000

30. Nama and address of parson who completed cause of death (Item 23a) (Type, Print)

The Address of parson who completed cause of death (Item 23a) (Type, Print)

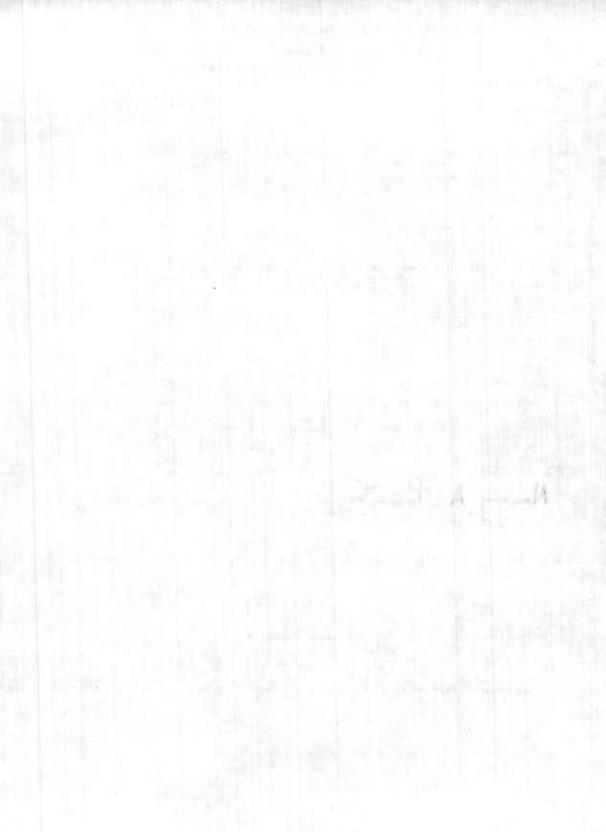
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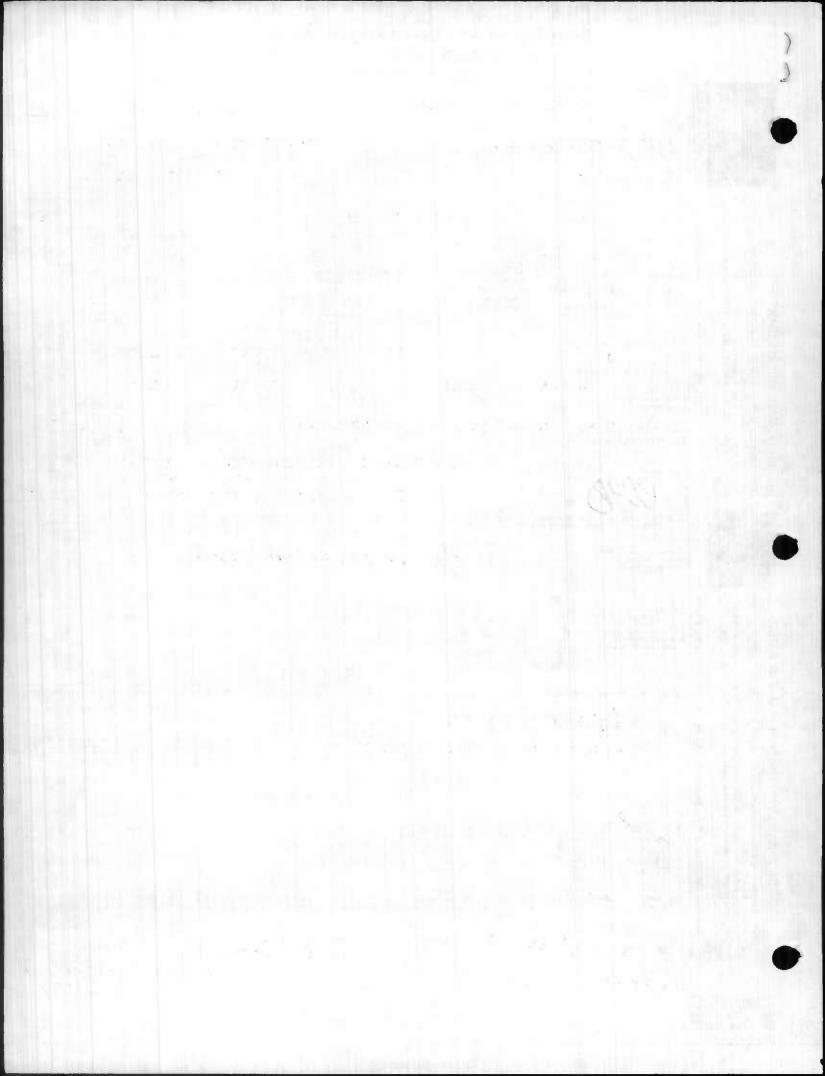
State Registrar

31. Data filed (Month, Day, Year)
OCT 0 4 2000

1. Registrar's Signatura



1. Decedent's Name (Frst, Middle, Last) FREDA JOSEPHINE BODEN 2. Dete of Deeth Ronth SEPT. 25, 2000 2:05 2:05 2:05 2:05 2:05 2:05 2:05 2:05				Olai	.5 or mar	yland / Dep <i>Ce</i>	rtificate					Reg. No.	O O	3	661	6
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4 Cor, Town, or Location of Death 4 127 TURKEYFOOT RD. 5 Stoods Security Number 5 Stoods Security Number 6 Store of Behavior Store of Death 100 Carroll 100 Carro			FR	EDA JO	SEPHIN	NE BODE	N								2:05	PM
Social Search Number County F. Aga (in yr. as at principle) Elevis (1 Search Elevis (2 Her. 1 Librar (2 Her. 1 Li		4e Fecility Neme	(If not institution	n, give street an	nd number)			- 1	4b. City, To	wn, or Lo	ocation of Dea	th 4c.	County	of Deeth		
215-14-2448 Total Age Street and Number		4127 1	TURKEY	FOOT R	D.								ARRO	OLL		
Total Size of and Number 10c. Carry 10c. Clay, Town or Location WESTMINSTER 10d. Carry														Cour	ntry)	or Foreig
Top. Celly Top. Celly Top. Celly Top. Celly Top. Celly Top. Cells Top				25		01 113.					6/13	/191	9 1	MARY	LAND	
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11. Married Status 12. Wise Decedent Feer in U.S. 12. Wise De	ľ	10e. Street end No	lumber				10f. Zip 0	ode				10g. Citi	zen of W	het Cour	ntry?	
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19. Mother's Name (First, Middle, Majdres) 19. Mother's Name (First, Middle, Name, Rate, Total Name, Part Name, P		Elementery/Sec	_	Colle	ege (1-4or 5+)	D	IETAR:	YI	EPAR	TME	NT	НО	SPI	TAL		
19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAWRENCE E. BODEN-HUSBAND 412 TURKEYFOOT RD., WESTMINSTER, MD. 27 20e. Method of Disposition I Buriel 2 Crametion 3 Removel from State Donetion 5 Other (Specify)	Ì	17. Fether's Neme		Last)					18. Moth	er's Nam	e (First, Middle	e, Maiden	Sumema	a)		
LAWRENCE E. BODEN-HUSBAND 4127 TURKEYFOOT RD., WESTMINSTER, MD. 22 20e. Method of Disposition 3 Remove I from Stata 20e. Location	١		JA	MES	REI	ESE			CA	THE	RINE	S	WOP	E		
20b. Place of Disposition 1		19a. Informent's I	Neme/Reletions	ship (Type, Print	t)	19b. Mai	ling Address (Street	and Numb	er or Rur	al Route Num	ber, City o	r Town,	State, Zip	Code)	
Marie 2 Carnelton 3 Removel from State 2 Carnelton 5 Other (Specify)				BODEN-	and the same of the last of the same of th				FOOT	RD						158
22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 2 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errost, index of percentage or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, bearing to immediate Cause (Disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause (Disease or injury that inheled avants resulting in death) Lest Dice Less Mellotte (IfUS) 24e. Was an autopsy performed? 24b. Were autopsy performed? 24c. Was an autopsy performed? 25c. Was case referred to medical examiner? 1 Yes 2 No Other: 4 Nursing Home St. Agistence Other (Specify) 27. Menger of Death Check only one) 28c. Time of Injury 28c. Ti				3 ☐Removel	from Stata	cemetery, cri	ematory or oth	er pla		1				-		
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State of Maryland / Department of Health and Mental Hygiene

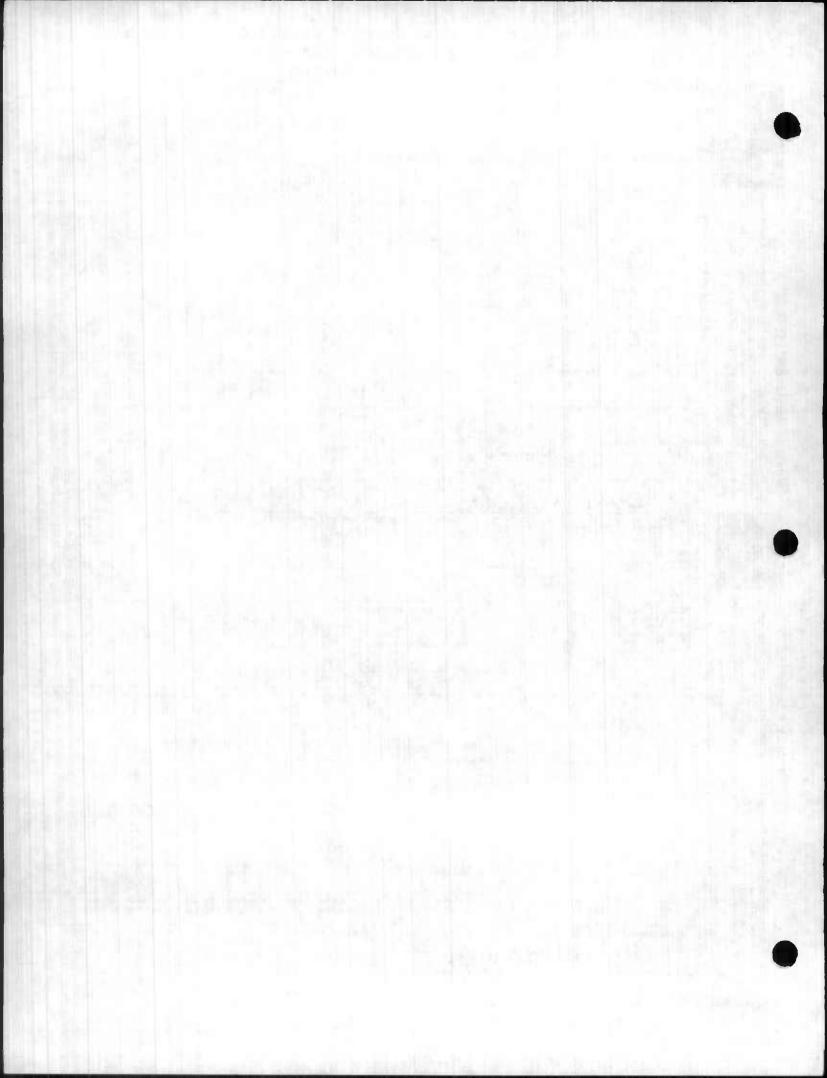
Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Betty Lou Brosenne Sept. 23, 2000 4:46am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Yaar | If Undar 24 Hrs. 8. Data of Birth Month, Pay, Year) Dec 19, 1936 5. Social Security Number 7. Aga (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 10M QF 63 Maryland 216-54-2936 Yrs. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or items 23s or 28s-f ehon traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Howard Marriottsville **Funeral Director** 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11376 Barley Field Way 21104 U.S.A. 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: Completed by 3 XWidowed 4 ☐ Divorced "natural". 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Store Owner Convenience Store Maryland 18. Mother's Name (First, Middle, Maiden Surneme) 17. Falher's Nama (First, Middla, Last) should be David Lee Green Betty Lee Schrader 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peges 1 and 2 s ment of Health en permit. Peges 1 and 2
Department of Health elimportant: If Item 27 le
any Injury or other trat . Mrs. Cindy Lee Floyd (Daughter) 11376 Barley Field Way, Marriottsville, MD 21104 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 9/27/00 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses PARTGAT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications the clused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or much line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Dua to (or as a consequence of): Physician/Medical Examiner September Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. been signed by the attending physician should be dateched for use as the buria Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No Probably 4 Unknown of Vital Records, by 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? certificate has 1 ☐ Yas 1 Tyes Be 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 | Nursing Home 5 | Rasidence Stother (Specify) NITU Z 1 Yes 2 -No 2 27. Manper of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred or Attending I after death. Division Natural 2 Accident 5 Panding investigation 1 Yes 2 No **Director:** 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide within 24 hours a
To the Funeral C
completaly filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Continued in the death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a Certifier edical 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) Baltimore, MD a. 11. caus MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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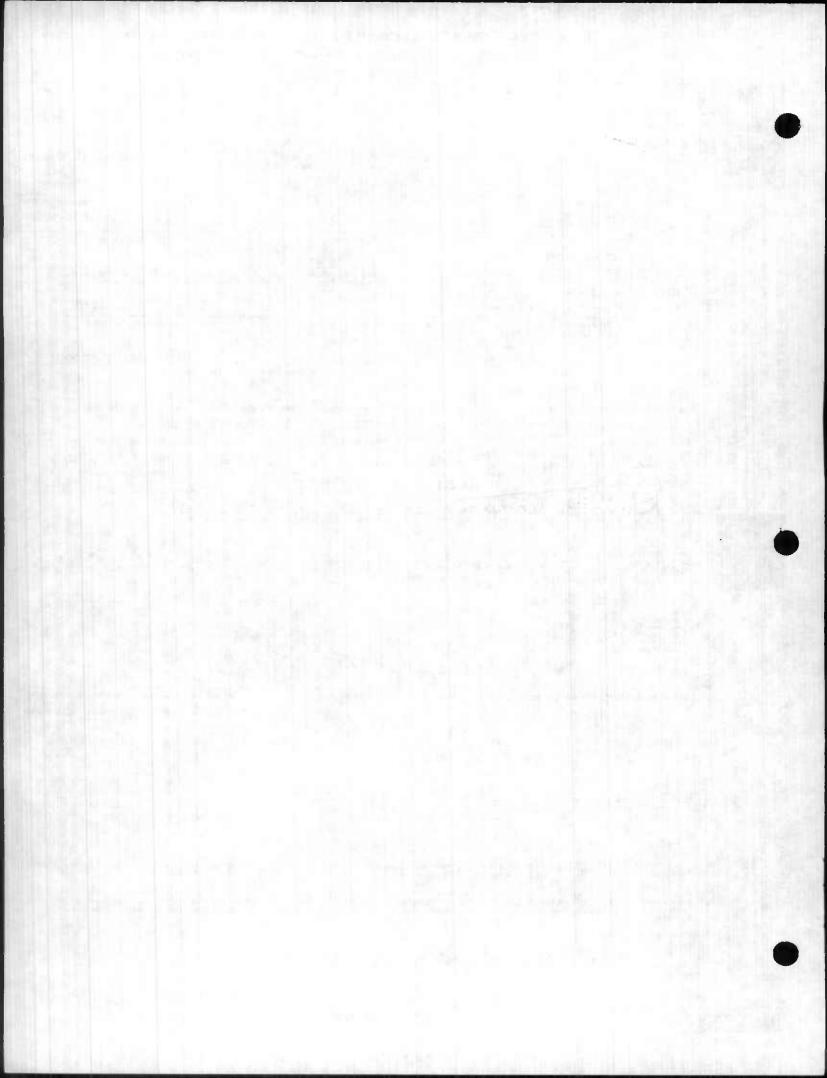


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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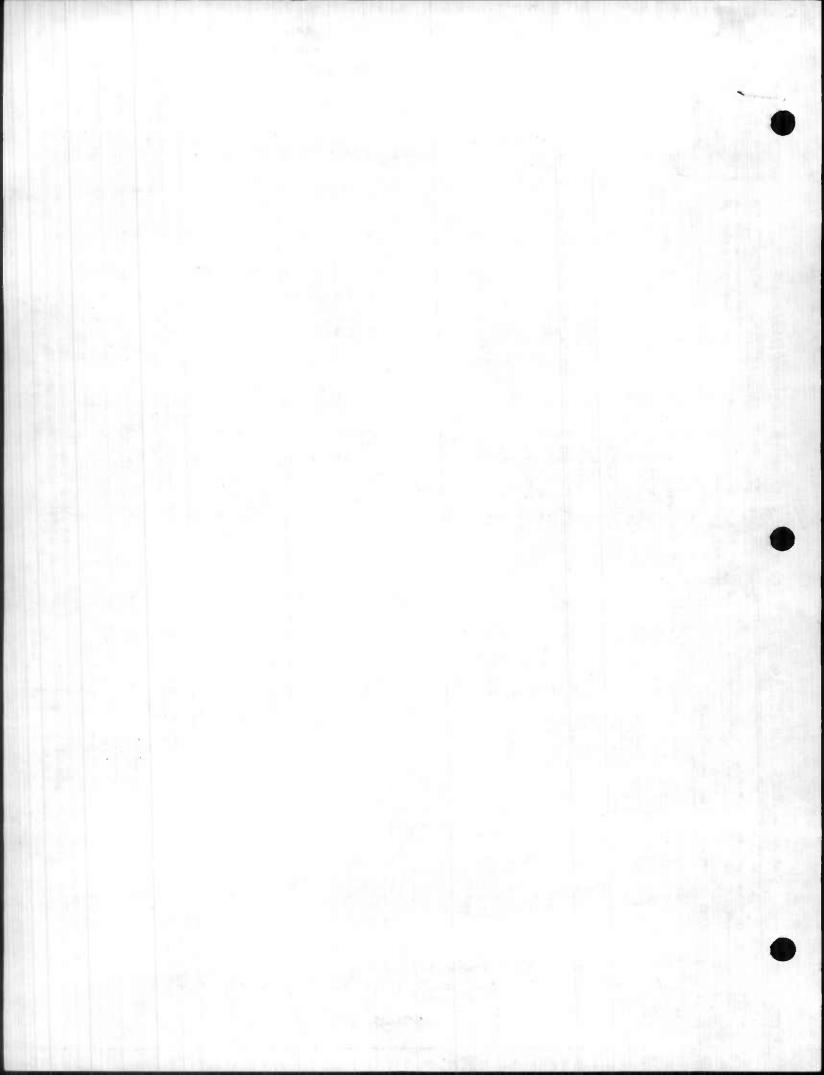
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

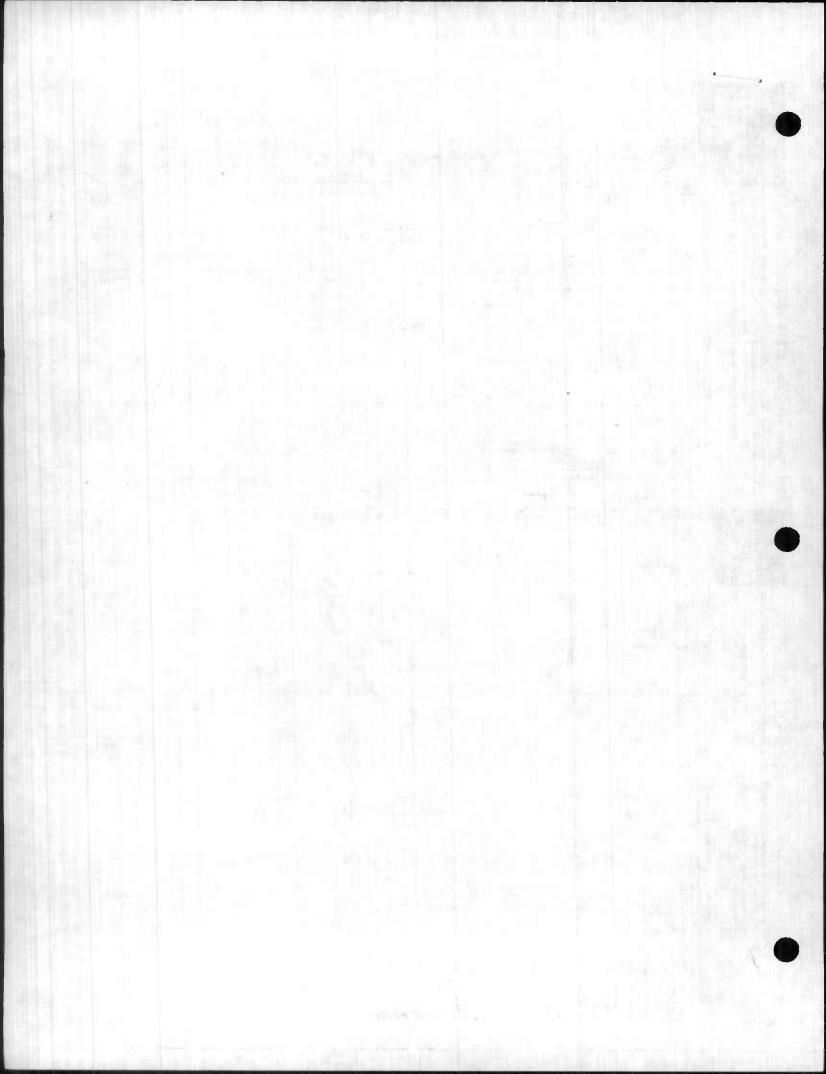
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician AMES 6:10 PM 2000 /Medical 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne ARUNde ANNAPOLIS, MD ALTH & 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days MM 2DF 219-03-1918 Director Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits th end Meniel Hygiens. 7 is marked other than "natural", or frama 23a or 28a-f ahov traumatic event, the Mesical Examinar must be notified at 1□Yes 2⊋No Director Tracys Landing Anne Arundel 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6271 Solomons Island Road U.S.A. 20779 Funeral death 12. Was Decedent Ever in U,S.
Amped Forces?
12 Mayes 2 □ No 1942
If Yes, Give Year or Dates: 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) t4. Race - American Indian, Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married Specify: White 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Project Manager Industrial Construction Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 end 2 ahould be file Depertment of Health and Mentel Hy important: If Nem 27 le marked othe any Injury or other traumatic event ange. 8 John Blackstock Nannie Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Eleanor Blackstock (Wife) 6271 Solomons Island Road, Tracys Landing, MD 20779 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Oct. 6, Davidsonville, MD 1 Buriat 2 Cremation 3 Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial Gardens 2000 21. Signature of Figure Septio L 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart lailure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) MUNDA Examiner physicien end the burial-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as e consequence of): a datached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown signed t Division of Vital Records. ò 24b. Were autopsy lindings available prior to completion of cause ol death? 24a. Was an autopsy performed? Completed has 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physicien: funeral director. Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 5 Pending To the Hospital or Attandir Within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 the death examination of the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signatura and title of g 29c. License number 29d. Date signed (Month, Day, Year) uss of passon who completed cause of death (trem 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) 32. Registray's Signature State OCT 04 2000 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician RUBY LEE CROCKETT G 4:11 pm 00 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL CENTER If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Feb. 19,1939 9. Birthplaca (State or Foreign Country) Indiana 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Yrs 309 42 5633 Director Usual Residence of Decedent deeth with the Manyland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health end Mental Hygiene. Important: If Itam 27 ie marked other than "natural", or itama 23a or 28a-f ahov any injury or other traumatic event, the Medical Examinar maint be notified as 1 Yes 2 No Director Washington D.C. 10a. Street and Number 10f. Zio Code 10g. Citizen of What Country? USA 20020 1617 T. Street SE Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. Specify: py Black. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 12th College (1-4or 5+) Office Manager Private 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Odessa Johnson Reuben Butler 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 10187 Campus Way South Upper Marlboro, MD 20774 Sandra Butler /sister 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) Entombment Washington National Cem. 9-29 Suitland, Maryland ¹22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD 21. Signature of Funeral Service Licenses 4308 Suitland Road Suitland, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final METASTATIC disease or condition resulting in death) OUARIAN CANCETE Examiner Due to (or as e consequenca of): Examiner sician and buriel-transit ECTROLYTE IMBALANC or Attending Physician: The law requires that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): physician s P.O. Box 68760, BOWER OBSTRUCTION Physician/Medical Due to (or as a consequenca of): 5672515 PULMONARY CONGESTION Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach 1 ☐ Yes 2 No 3 Probably 4 Unknown Records. Aq 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en eutopsy 1 ☐ Yes 2 XNo 1 Yes 2 No Division of Vitai director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2♥ No 1∑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation 24 hours after deal Funeral Director: 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital Medical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and manner stated. within 2 ş сотрів 29b. Signature end title of certifie 29c. License number 29d. Date signed (Month, Day, Year) To 9 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 3001 Chevery MD 31. Date filed (Month, Dey, Year) SEP 2 6 ZUUU 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 2 2

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by F.	1 Never Merried 2 Merri 3 Widowed 4 Divorced	ed typyres 2 1 If yes, Give Year or Detes:	1953	1 □ Yes				Specify	Whit	te
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To B	Edward F	. Clark				Mary	Agnes	Wrigh	nt	
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State of Maryland / Department of Health and Mental Hygiene

				Certificate of	Death	Reg	J. No.	36666
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	Examiner	4e Facility Name (If not institution, given	ve street and number)		4b. City, Town, or Lo	cation of Death	4c. County of	
		Crescent Cities Cent	er		Riverdale	2	Prince	e Georges
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alti	pemit. Pag Department Important: I sny Injury o	21. Signature of Funeral Service Lice	9500	22. Name end Add		Stewart I		
ä	Ded Imperior	Dal T	Toward TIT	4001 H	Benning Rd	., N.E. V	Vash., I	O.C. 20019
		23a. Pert / Enter the disease, or com shook for heart teilure. List only	iblications that caused the death.	Do not enter the mode of dy	ring, such es cerdiac o	or respiratory erres	it,	Approximate
	Physician	shoot for heart tellure. List only	one ceuse on each line.					Onset and Deeth
250	/Medical	Immediate Cause (Finel	0-	1. ()	1			10
	Examiner	disease or condition resulting in deeth)	a. The large	s a consequence of):	Emant)>()	_	ーノラン
	وَ السَّاسِ السَّاسِ السَّاسِ السَّاسِ السَّاسِ السَّاسِ السَّاسِ السَّاسِ السَّاسِ السَّاسِ السَّاسِ السَّاسِ		Spe to (or a	s a consequence ory.				
	executed in and iel-trensit	Conventially list conditions	b	s e consequence of):				
Ć.	exec an an niel-tr	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
68760,	ficate be physicients the burner edical	that initiated events .	C. Due to (or es	s a consequence of):				
	rificate be executed ng physicien and sat the buriel-trensit	resulting in death) Last						
Box	eath cert ettendin I for use	SEXUAL TRANSPORT	d					
	at the death ce d by the ettendir eteched for use Physician/	Part II. Other significant conditions of	contributing to death but not resulting	ng in the underlying cause of	oiven in Pert I.	23b. Did tob	acco use cont	ribute to the cause of deal
P.0	ed by the deteched		00 111	, and the control of		1□ Yes	v	3 ☐ Probably 4 ☐ Unkno
	es that igned l		2 Plellite	N				
of Vital Records,	been s should					24a. Wes an perform	autopsy ed?	24b. Were autopsy finding evailable prior to completion of cause of deeth?
Re	The law ate has page 2					1 ☐ Yes	2 × No	1 Yes 2 No
ā	ysicism: The last certificate had director, page	25. Wes cese referred to medical			00 Binn of Door			10 105 20 100
5	s certification of Be	examiner?	Hospital:		ther:	h (Check only one		/Constant
ot	5 5 6	1 ☐ Yes 2 ☑ No 27. Manner of Deeth		Voutpetient 3L DOA	4 tal Nursing Ho	me 5 Residen		17. 77
L C	Bu Bu	1 ☑Naturel 5 ☐ Pending	(Month, Day Year)	Injury W	ork? ☐ Yes 2 ☐ No			
S	Attending or death. ector: After by the fune	3 Suicide 6 Could not t	De Diese of Injury At hom			28f. Location (Stre	et and Numbe	r or Rural Route Number,
Division	tal or Attending P rs after death. al Director: After i ied in by the funer Certification:	4 Homicide determined	building, etc. (Specify)	e, territ, street, factory, onto		City or Town,		
_	illed C	29e. Certifier 1☐ Certifying Pl	huminians. To the heat of my knowle	adae death accurred at the	time date and place	and due to the car	see(s) and man	ner as stated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the it Medical Certificati		hysician: To the best of my knowle miner: On the basis of examination end menner steted.					
	Me the	29b. Signeture, and 4the of dertifler	Conditional states.	29c. Lice	nse number	29	d. Dete signed	(Month, Day, Year)
3	T VIII	OF V	Of Sigh	MD D	45 660		-28 -	
	(14)			2-1/T 0-1-11				
	(7)	30 Name and address of person who		3e) (Type, Print) × (N, 12	M, Bos	lie r	10 2	e715
	Chat		22. Registrer's Signatur					
	State Registrar	31. Date filed (Month, Day, Year) SEP 2 9 2000	1 30 mas 1	I have	,			



	State of Maryland	d / Department of Certificate of			UU	32223
Decedent'e Neme (First, Middle, Last))	Continuate of	Douth	2. Dete of Death	. No.	3. Time of Death
	CONWAY			Month	Day Year	11.08.
4s Escility Name (If not institution give			4h City Town or	Location of Death	4c. County of Deat	11.01/4
Doctors Community						
5. Sociel Security Number 6. Sex		ast birthday) If Under 1 Year	Lanham	8. Date of Birth	Prince Ge	
	M 2⊠F 63	Yrs. Months Deys	Hours Min			hplace (State or Foreign untry)
Usuet Residence of Decedent				April 9,	1937 AI	abama
10a. Stata 10b. County	10c. City	, Town or Location				10d. Inside City Limits
Maryland Prince Ge	orge's Col	llege Park				1⊠ Yes 2□ No
Maryland Prince Geo 10e. Street and Number 4718 Lakeland Roa 11. Marital Status 1□ Never Merried 2□ Married		10f. Zip Code		10g	. Citizen of What Co	untry?
4718 Lakeland Roa	nd	2074	40		U.S.A.	
11. Marital Status	12. Was Decedent Evar in U,S Armed Forces?	5. 13. Was Decedent of	1.4	Specify Yas or No-	14. Race - Ame Black, White	
1 Never Merried 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🖾 No	1 ☐ Yes 21 No		no rioan, atc. j	Specify: Bla	1000
3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	10100 2,0110	opecity.		Specily: DIA	CK
15. Decedent's Edu (Specify only highest grade Elementary/Secondery (0-12) 10th 17. Father's Name (First, Middle, Last) Benny Woods		16a. Decedent's Usuel Occu	ipation a during most of wo	orkina 16	b. Kind of Business/	ndustry
Elementary/Secondery (0-12)	Cottege (1-4or 5+)	(Give kind of work done life. DO NOT use retin	9d)			
10th		Housewife	1		Private	
17. Father's Name (First, Middle, Last)				me (First, Middle, Ma	,	
Benny Woods			Henri	etta Barn	ett	
19e. Informent's Name/Reletionship (Ty)	rpe, Print)	19b. Meiling Address (Street	et and Number or R	lural Route Number, C	City or Town, Stele, 2	ip Code)
Ayanna Garment/Da		4718 Lakeland	Road, C			
20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ R	0.0	ece of Disposition (Neme of metery, cremetory or other plant	∍∞)Park	09/25 20	c. Location - City or	Town, State
4 □ Donetion 5 □ Other (Specify)	Mar	yland Nationa	1 Mem.	2000 La	urel, Mar	yland
21. Signature of Funeral Sarvice License	ne II	J.B. JENK	ess of Fecility	AT HOME		
Nancin A	P. T.			Landover	Marvlan	4 20705
23a. Part1. Enter the dispese, or complishook, or heart failure. List only on	cetions thet caused the death.	Do not enter the mode of dy	ing, such es cardia	ic or respiretory erres	, maryrai	Approximate Interval Between
SHOCK, OF HEART TAMES. LIST OTHY OF	ie ceuse on eech line.				1	Onset and Death
Immediate Cause (Finet disease or condition resulting in deeth)	Cowbi	ISTUE HE	ant t	By Line 13		YBARS
	2 1 1 1	es a consequence of):	11		1	1 11
Sequentially tist conditions, if any, leading to immediate	Due to (or	as e consequence of):	1			
Losuse Enter Underlying	ATNIB	1 FIRMU	Mon	1	1 t	le 11
that initieted events resulting in death) Lest		es a consequence of):				
	Mypray	AUS10N				14
Pert ii. Other significant conditions con	tributing to death but not rasul	lting in the underlying cause g	iven in Part I.	23b. Did toba	cco use contribute	to the cause of death?
Cause (Disease or injury that initiated events resulting in death) Lest Pert II. Other significant conditions con	18,20			1 🗆 Yes	2 No 3□PI	robably 4 Unknown
				24a. Wes an		Were autopsy findings
				performe		evailable prior to completion of cause of death?

25. Was once related to modical				1 Yes	21X140	I ☐ Yes 2 ☐ No
25. Wes case referred to medical examiner?	lospitel:	- D/O	thor	eth (Check only one)	о Пон на	-4.4
1 Yes 2 No	1 Linpatient 200 E	Proutpatient 3 DOA	4 LI Nursing	Home 5 ☐ Residence 28d. Describe how		опу)
1 Naturel 5 Pending investigation	28a. Dete of Injury (Month, Dey Year)	Injury Wo	ork?]Yes 2□No			
3 Suicide 6 Could not be determined	28e. Ptece of Injury - At hor building, etc. (Specify)	ne, farm, street, fectory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	iral Route Number,
	sician: To the best of my knowner: On the basis of examination and menner steted.					
29b. Signeture and fittle	71.110		ise number	290	. Date signed (Month	h, Day, Year)
med	N Hilley	-NIV -10	1576	6	9/21,	100.
30. Name and address of person who con Samuel W. Alleyne			Landove	r, Marylan	d 20785	

State Registrar

Physicia /Medica Examine

Funeral Director

"natural", or flams 23a or 25a-f shor

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish transit

Division of Vital Records, P.O. Box 68760,

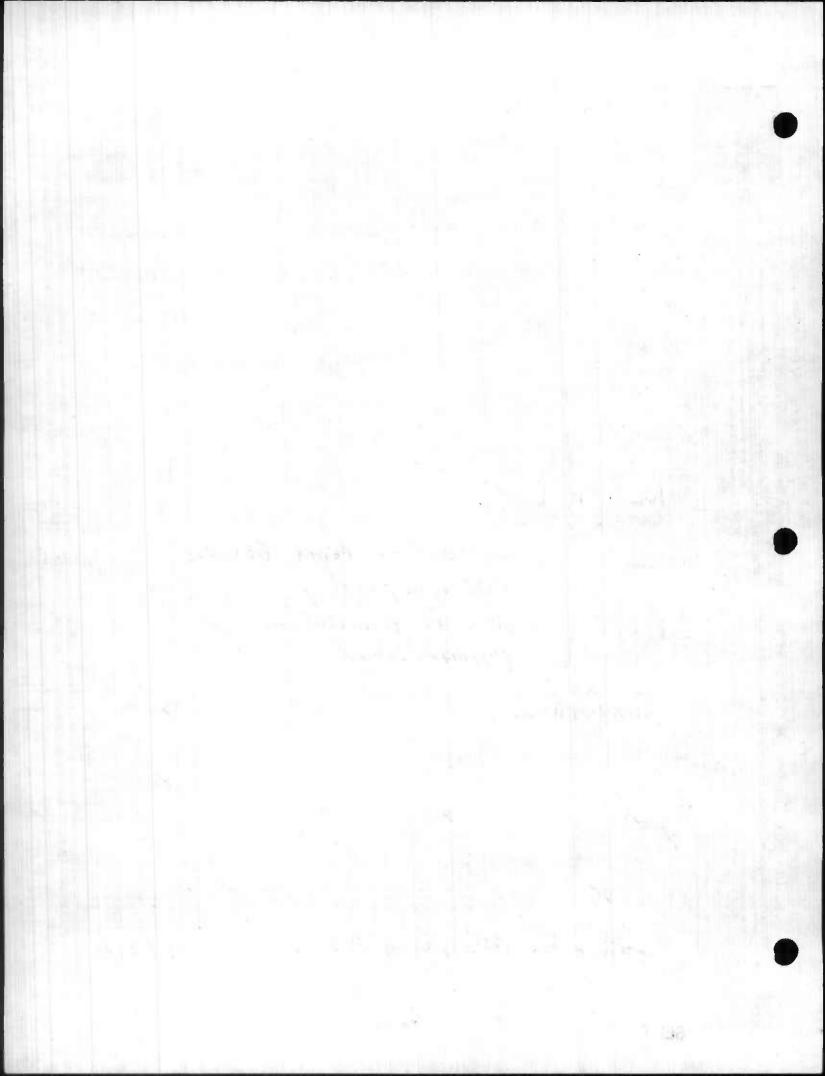
be filed within 72 hours after

Baitimore, Maryland 21215-0020
Count. Pages 1 and 2 should be a constructed to the construction of the con

DHMH 16 Rev 6/95

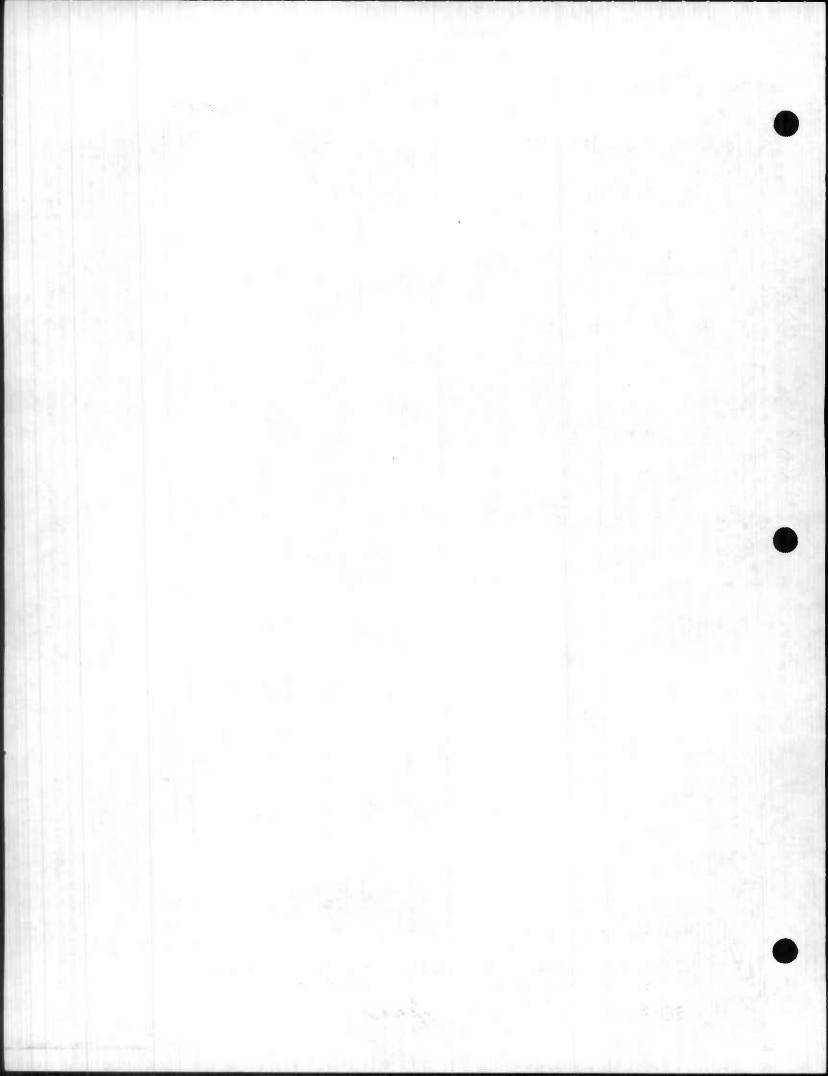
31. Defe filed (Month, Dey, Year)

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Carter Carlton A. September 20 2000 8:50 P.M. /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner Civista Medical Center LaPlata Charles If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Day Year) 9. Birthplace (State or Foreign Country) Mar . 20 , 1937 Washington, DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Hours 1**X**) M 2□ F Yrs. 579-46-2564 Director 63 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Upper Marlboro 1 ØYes 2 □ No Maryland Prince George Directo 28a-1 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Coda 8 20772 12221 West View Drive 238 Funeral 12. Wes Decedent Ever in U.S. Amped Forces? 1953 – 1 X Yes 2 No If Yes, Give 1957 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Raca - American Indien, Bleck, White, etc. 11. Meritel Stetus African American 1 Never Merried 2 Merried 6 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Detes: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elemantery/Secondary (0-12) Collega (1-4or 5+) Government Police Officer 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surneme) merked of Marie Robinson Carter . Pages 1 and 2 should be ment of Health and Menta ant: If Nem 27 is merked Samuel and a 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9881 Goodluck Rd., Lanham, Md. (20706) 19e. Informent's Neme/Reletionship (Type, Print) Donald E. Carter (Son) 20b. Place of Disposition (Neme of cametery, crematory or other pleca) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from State Lincoln Memorial Cem 9/27/00 Suitland, Md. 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Funeral Service Licensee ^{22. Name end Address of Fecility}Stewart Funeral Home, Inc. 4001 Benning Rd., N.E. (Wash., D.C. 20019) that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errast, to on each line. 23a. Part . Enter the disease, or shock, or heert failure. List Onset end Death Physician Immediate Cause (Final diseese or condition resulting in deeth) /Medical Examiner Due to (or es a consequenca of) Physician/Medical Examiner The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or es e consequence of) Box 68760, physician the Due to (or es e consequence of) use es Pert II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? detached P.O. 1 Yes 2 1 M6 3 Probably 4 Unknown 2 of Vitai Records, P 24b. Wara autopsy findings aveilable prior to completion of cause of deeth? 24e. Wes an autopsy performed? Be Completed page, 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case rafarred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manney of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Division Injury 1 LUNatural 5 Panding aftar death. 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Steta) 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, atc. (Specify) filled in by 4 Homicide within 24 hours a Hospital 12 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the causa(s) end menner es stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the tima, data and place, and due to the causa(s) end menner stated. 29a. Certifier Medicai pletaly (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and titla of contilier 29c. License number D- 0021031 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 12070 Old Line Center Suite 202 Michael A. Leatherwood, M.D. Waldorf, Maryland 20602 32. Registrer's Signeture State Registrar



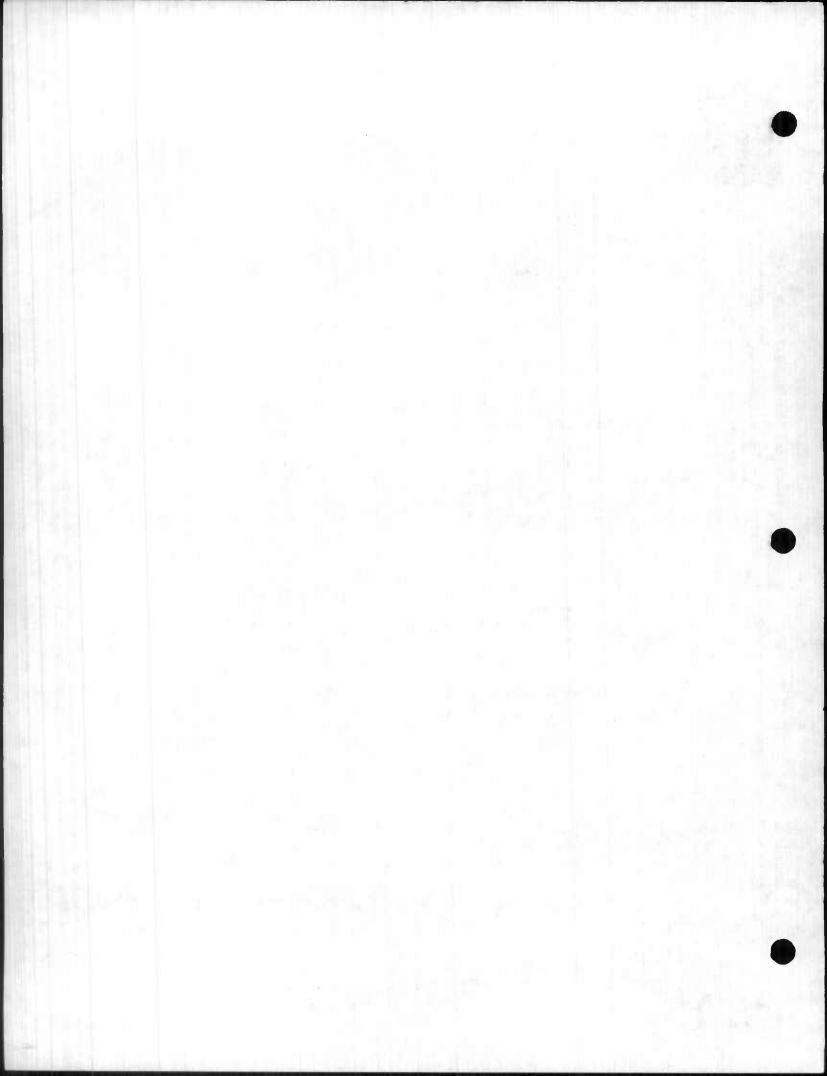
State of Maryland / Department of Health and Mental Hygiene 11 32225

Certificate of Death	leg. No.
Decedent's Neme (First, Middle, Last) 2. Date of Dea Month Month	th 3. Time of Death
Physician Alice Mildred Carpenter Sept.	23 2000 12:35 P.M
Examiner 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death	4c. County of Death
Glady's Spellman Nursing Center Cheverly	Prince George's
Funeral Director 5. Social Security Number 6. Sex 1 Months 1 May 1 Months 1	Year) 9. Birthplece (State or Foreign Country) Washington DC
Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location	10d. Inside City Limits
10a. Stata 10b. County 10c. City, Town or Location Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 1	1 ☐ Yes 2⁄0XNo
Maryland Prince George's Temple Hills 10e. Street and Number 10o. Street and Number 10o. Street and Number	Og. Citizen of What Country?
3103 Marilyn Drive 20748	United States
11. Meritel Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	t4. Race - American Indian,
1 Tes 2 Married 1 Tes 2 Marri	Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working	16b. Kind ol Business/Industry
15. Decedent's Education (Specify only highest grade completed) [College (1-4or 5+)]	
12 0 Homemaker 17. Father's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middle, Last)	Own Home
17. Father's Neme (First, Middle, Last) James Owens 18. Mothar's Neme (First, Middle, I Annie Thomas	Walden Sumeme)
James Owens Annie Thomas	Charter Con To Code
19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number P.O. Box 94 Deale Maryland 20	
CTOL Wrodoriok K Corportor	
O O S & Demoust from State Completon Company of Company	Brontwood Maryland
4 Donation 5 Other (Specify) 21. Signeture of Funeral Service Uconsec 22. Nama end Address of Facility Robert F. Evans Funeral Ho	Brentwood Maryland
Robert E. Evans Funeral Ho	ome
Robert E. Evans Funeral Ho 16000 Annapolis Rd. Bowie 23a. Pertl. Enter the disease, or complications that valued the deeth. Do not enter the mode of dying, such as cardiac or raspiretory errors shock, or heart feilure. List only one cause of such inter.	Maryland 20715
shock, or heart feilure. List only one cause of the control of the	Interval Between Onset and Death
Medical Immediate Cause (Final	man of
disease or condition resulting in death) Due to (or es e consequence of):	MICHOLD
(O(O)) A Gelm all as	e 1/1
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of):	
Sequentially list conditions, if ery, leading to immediate cause. Enter Underlying Cause (Disease or Injury C.	
we have a second to infinitely to assect the following cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es a consequence of):	
S S S S S S S S S S S S S S S S S S S	
d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did to	1
Description of the state of the	obacco use contribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did to	es 2 146 3 Probably 4 Unknown
Ø 8 68 G	O4h Mars outeroutis discuss
24a. Wes e performance of the pe	n eutopsy med? 24b. Were autopsy findings evailable prior to completion of cause
A Se le le le le le le le le le le le le le	of death?
	es 2 Mo 1 Yes 2 No
25. Was casa relerred to medical examiner? 1 Yes	
1 Inpatient 2 EP/Outpatient 3 DOA 4 Infraring Home 5 Reside	
O & S 27 Mannar of Death 28e Date of Injury 28h Time of 28c Injury at 28d Describe h	
27. Manne of Death 28a. Dete of Injury 28b. Tima of Injury 28b. Tima of Injury 28c. Injury at Work? 1 Phatural 5 Pending Investigation	ow injury occurred
27. Manne of Death 1 Invatural 28d. Detect Injury 28b. Tima of Injury 28c. Injury at Work? 1 Invatural 2 Accident 3 Suicide 6 Could not be determined to the project 28a. Detect Injury 28b. Tima of Injury 28b. Tima of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe here.	treet and Number or Rural Route Number,
27. Manne of Death 1	treet and Number or Rural Route Number,
27. Manne of Death 1	treet end Number or Rural Route Number, n, Stete) ause(s) and mannar as stated.
27. Manne of Death 1	treet end Number or Rural Route Number, n, Stete) ause(s) and mannar as stated.
1 Indiatural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be detarmined 28a. Place of Injury · At home, ferm, street, lectory, office 28f. Location (Socity or Town one) 29a. Certifier (Check only one) 1 Certifying Physician: To the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to that can manner steted.	treet end Number or Rural Route Number, n, Stete) ause(s) and mannar as stated.
27. Manne of Death 1 Thatural 2 Accident 3 Suicide 4 Homicide 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Yes 2 No 28d. Describe h 28d.	treet end Number or Rural Route Number, n, Stete) ause(s) and mannar as stated. late and place, and dua to the cause(s)
27. Manne of Death 1 That ural 2 Accident 3 Suicide 4 Homicide 28a. Dete of Injury 28b. Time of Injury at Work? 1 Yes 2 No 28d. Describe he work? 1 Yes 2 No	treet end Number or Rural Route Number, n, Stete) ause(s) and mannar as stated. late and place, and dua to the cause(s)
1	treet end Number or Rural Route Number, n, Stete) ause(s) and mannar as stated. late and place, and dua to the cause(s)

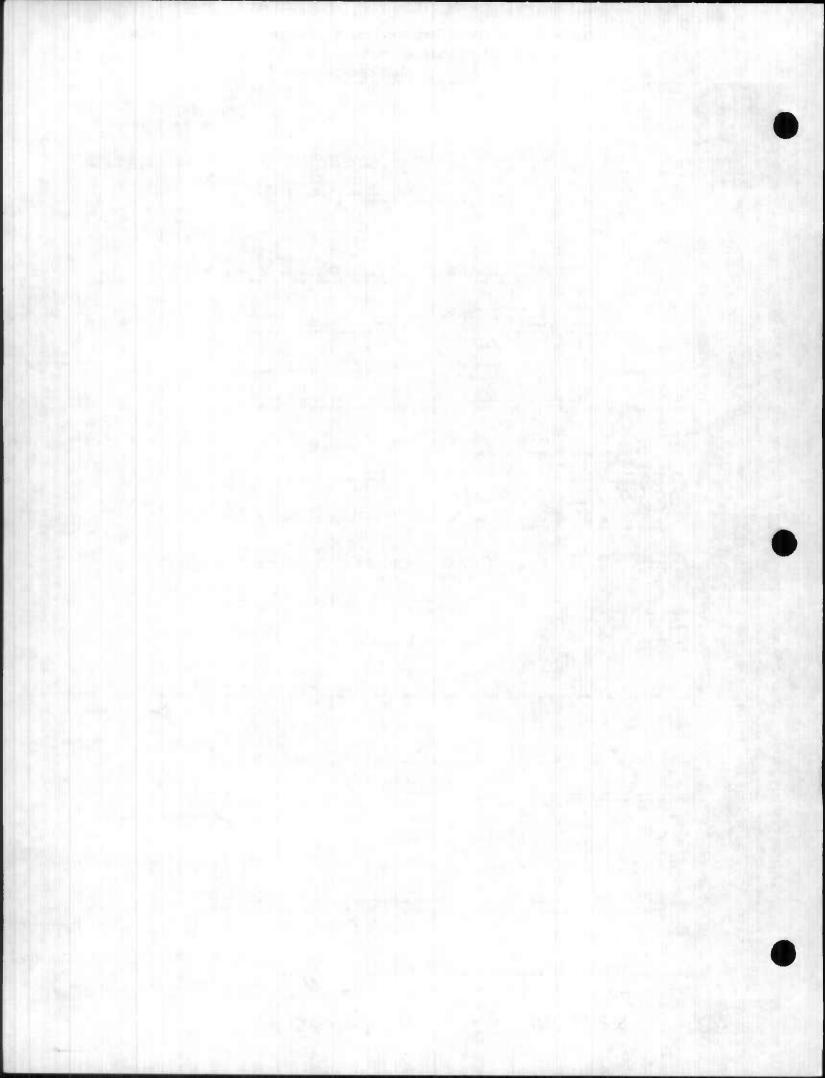


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death Month Day **Physician** SEPT Dorothy E. Carroll 29 10:42 PM 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner CIVISTA MEDICAL CENTER IAPLATA CHARLES If Under 1 Year 8. Data of Birth (Month, Day, Year) 01-16-1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days Hours Min 1□M 2X0 F Yrs. 84 Maryland **Director** 220-16-1916 Usual Rasidence of Decedent 10c. City, Town or Location 10d. Insida City Limits 10a, Sfate 10b. County ns 23e or 28e-f show must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Charles Nanjemoy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 20662 United States 3211 Poseytown Road Funeral 12. Was Decedenf Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Give Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 Nevar Married 2 Married 8 1 Yes 2XXIIo Specify: Specify: Black þ XXWidowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grada complated) Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker Others Homes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Health and Mental Lena H. Henson Lemual Carroll 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) important: if hem 27 is any injury or other treum Michele Adams/Granddaughter1835 East Wolfchase Circle, Cordova, Tennessee Baltimore, 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, State cematary, cramatory or other place)
arch of The Lord 10 - 031 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Church of Ironside, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Jesus Christ Cemetery 2000 22. Nama and Addrass of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service Licensee 20640 M00668 4270 Hawthorne Road, Indian Head, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart militure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Death **Physician** tmmediata Causa (Final disaasa or condition rasulting in death) CANCER OF VULVA. /Medical **Examiner** Physician/Medical Examiner AN CEN Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last The law requires that the death certificate be execu AWKS of MALIGNAMON Box 68760. PYERCALCEMIA Due to (or as a consequence of) IGHT LUNG 0.0 Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably Wunknown IDNEW MASS by Records. 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performad? Be Completed page 2 No 1 ☐ Yas 2 ☐ No 1 Yas certificate Division of Vital Hospital or Attending Physician: 25. Was casa refarred to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Inpatient 2 EN/Outpatient 3 DOA Medical Certification: To this 28a. Data of Injury (Month, Day Year) 27. Manper of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? After 5 Panding invastigation 1 Natural after death. Director: Aft d in by the fur 1 Yas 2 No 2 Accident 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 Homicide within 24 hours aft To the Funeral Dis completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) 29c. Licansa number 00 0 D-20629 irson who complated causa of death (Itam 23a) (Type, Print) 30. Name and address of pe GEORGE H. WATHEN MD 11345 PEMBROOKE SQ. SUITE #103 WALDORF, MD. 20603 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Registrar



							Ce	rtificat	e of	Death			Reg. No.		Cus Cus Cus I
			1. Decedent's Name (First,	Middle, La	ist)	40 100						2. Date of Dea	th Day	Year	3. Time of Death
	Physicia: /Medica		Harry St	anle	у Сох							Septemb	per 23	2000	10:45 PM
	Examine		4a Facility Name (If not ins. 9355 Woods			nber)					own, or L	ocation of Death		of Death rederi	ick
Ī	Funeral Director		5. Societ Security Number 076-16-1961		Sex 1⊠M 2□F	7. Age (In yrs. 78		H Under Months	1 Year Deys		24 Hrs. Min.	8. Date of Birt (Month, Day Jan. 23	, Year) , 1922	9. Birthpl Count New	ace (State or Foreign lay) York
	pu .	-	Usual Residence of Deceder 10a. State 10b. C			10c Ci	ty, Town or Lo	ocation						10	Od. Inside City Limits
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	ath with the Marylar 23e or 28e-f show	rai Dir	9355 Wood	sbor			7/5				1701			U.S.	. A .
Maryland 21215-0020	72 hours after death with the Maryland natural; or frems 23s or 28s-f show deal Eastmoon must be notified at	Completed by Funeral Director	11. Merital Status 1 □ Never Married 2 □ 3 ☑ Widowed 4 □ Div		Armed Fo	2 No				Hispanic Orban, Mexica		pecify Yes or No- Pican, etc.)	Specif	ce - America ck, White, e	
5-0	72 hours	etec		edent's E	ducation ade completed)		(Give	dent's Usu kind of wo	rk done	during mos	st of worl	king	16b. Kind of B	usiness/Ind	lustry
121	within ena.	Ē	Elementary/Secondary (0		College (1	-4or 5+)	life.	DO NOT u					const	ructi	ion
7	filed w Hygie ther th		17. Father's Name (First, M	iddle Last	1		1	Са	ı pe	nter 18 Moth	or's Nam	ne (First, Middle,			LOIL
and	ntal h	Be Be	Harry Stanle							TO. WICK		dred Per			
7	2 should be filed within end Mental Hygiena. Is marked other than surratic event, the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Men	2	19a. Informant's Name/Rel	ď			19h Maili	na Addres	: (Street	et and Numb		ral Route Numbe		State Zip	Code)
Ma			Julia C. Hoo					-				rederic	-		
e,	Heel Heel other	+	20a. Method of Disposition		0	20b. I	Place of Disp	osition (Na	me of			Dete	20c. Locetion		wn, State
Baltimore,	permit. Peges 1 and 2 should be filed within Department of Heelth end Mental Hygiena. Important: if them 27 is marked other than any injury or other traumatic event, the the page.		1 Burial 2 Crem. 4 Donation 5 Otl	er (Speci	fy)			Crema	tio	n, In		9/25/00			MD
Ball	Depart Depart Import any in		21. Signatory at Fungral Se	rvice Lice	O. Wa	then						tzler Fu Libert			1762
			23a. Pert 1. Enter the disea shock, or heart failure	se, or con	nplications thet c	avec the dee	th. Do not en	ter the mod	de of dy	ring, such as	s cardiec	or respiretory a	rest,		Approximate Interval Between
	Physician														Onset and Deeth
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		a. /	mas/	999	2016	4.	4	-4	mp.	6000		5 40
		Jer	resulting in death)			Due to (or as a conse	quence ot)						 	
o,	icate be executed physician and s the bunal-transit	Ехашпег	Sequentially list conditions if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	ſ	b. ———	Due to (or as a conse	quence ot):							
Box 68760,	E 0 8	In/Medical	that initiated events resulting in death) Last	J	d	Due to (d	or as a conse	quence of):							
	death e etter of for u	Physician	Part II. Other significant co	nditions	contributing to de	eath but not res	sulting in the u	inderlying (ceuse (iven in Part	1.	23b. Dld	tobacco use co	ontribute to	the cause of death?
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	uires that the de is signed by the e	2													
Records	aw requires ts been sign 2 should be	Completed by											en eutopsy rmed?	evi	ere autopsy tindings eileble prior to mpletion of cause deeth?
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Vital	certificata	20	25. Was case reterred to m	edicel		TOTAL T				26. Plac	ce of Dea	th (Check only o	one)		
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on of	Attending Phyrideath. ector: After thi by the funeral			ending		ot Injury th, Day Year)	28b. Time of Injury	of M	28c. Inj W	ury at ork? Yes 2] No	28d. Describe	how injury occu	rred	
Division	or Attender Director	Certification:	3 ☐ Suicide 6 ☐ 0	could not be letermined	280. Place	ot Injury - At h ng, etc. (Speci	nome, farm, si	reet, tactor	y, offic	9		28t. Location (City or To	Street and Num wn, State)	ber or Rura	I Route Number,
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	To the within 2 To the comple	Me	29b. Signeture and title of	ertifier				29	c. Lice	nse number			29d. Date sign	ed (Month,	Day, Year)
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			30. Name and address of p	erson who	completed ceus		m 23a) (Type				7 5	C- 7		-1.6	21701
	State	e	31. Date filed (Month, Day,	Year)		egistrer's Sign			,						-
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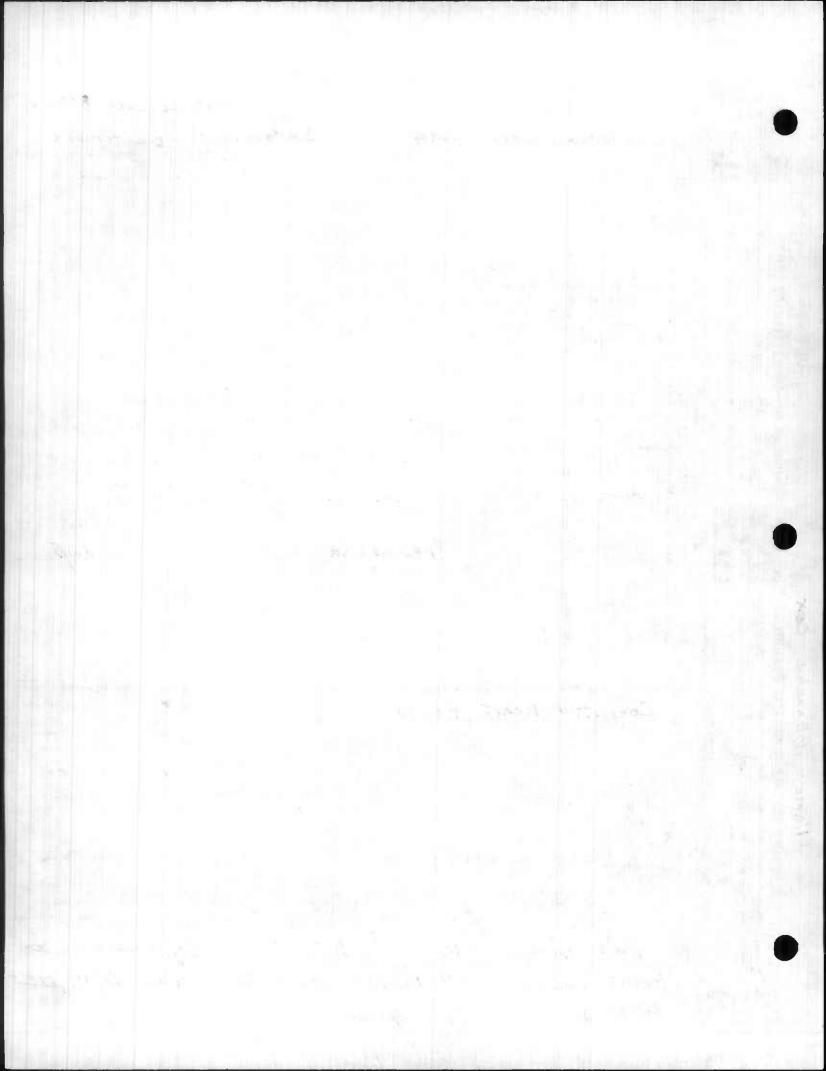
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Sept Year **Physician** 8:06 am 26,2000 Blanche E. Cox /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore Charlestown Care Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F 212-38-2374 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **ehow** ral', or itema 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 713 Maiden Choice Lane 21228 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 21215-0020 natural, or 1 Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7 Department of Heelth and Mentel Hygiene. Important: if Item 27 is marked other than *r any Injury or other treumatic event, the Mad Antice. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public School Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David Cox Eva Osborne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Giles / cousin 2110 Williams Dr., Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Belair Memorial Garden 9/30/00 Belair, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lisa M. Scott Funeral Services Ousa Scott 552 Lewis Street, Havre de Grace, MD 21078 Viam 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical neumo nia Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Congostive Heart failure 3 Probably 4 Unknown Records, 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Tyes 2 NO No 1 Yes 2 No of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after deeth Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical tely (Check only one) within 2 \$ 29b. Signature and title of certitier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maiden chance lane, catonsville, MD, 21226 10 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 7 2000 Registrar

DHMH 16 Rev 6/95

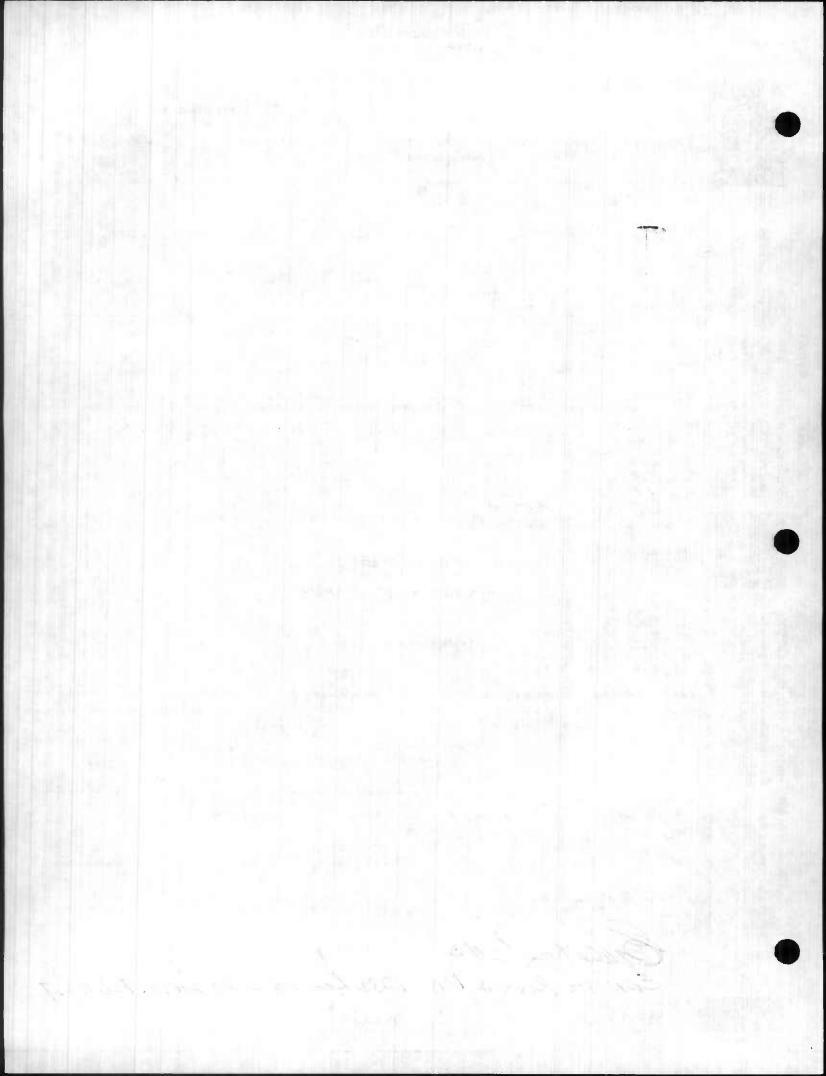
Blanche

Name



State of Maryland / Department of Health and Mental Hygiene 00 32229

		1. Decedent's Name (First, Middle,	Last)					2. Date of De Month	_	Year	3. Time of De
Physici		Kaylee May Cree	ese					SEPTEM	BER 27	2000	9:58
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		Usual Residence of Decedent					30min Se	- Peember	27,2000	Hai	yrand
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T In	Be	17. Father's Name (First, Middle, L	ast)				18. Mother's Nar	me (First, Middle	, Maiden Sumam	ne)	
the d	OB	Troy Creese					Shellv	Bosley			
th and Me 7 is marks traumatic	-	19a. fnformant's Name/Relationsh	ip (Type, Print)		19b. Mailing	Address (Stre	eet and Numbar or Ru		er, City or Town,	State, Zip	Code)
177 E		Troy and Shelly		/ parant			Lane, Ell				
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fler death. Irector: After this certificate has been signed by the attending In by the funeral director, page 2 should be detached for use a	edical Certification: To Be Completed by Physician/Medical	25. Wes case referred to medicel axaminar? 27. Mannar of Death 1 Natural 5 Panding investig: 3 Suicide 6 Could nedatamine (Check only one)	d. Hospital: 28a. Date (Mc ation of balled build physician: To the xaminer: On the	Due to (c Due to (c Due to (c death but not res a of fnjury onth, Day Year) ce of Injury - At h ding, etc. (Specia	OF ETENT or as a consequence or as a consequen	ence of): all DOA 28c. tr M 28c. tr 1 et, factory, office occurred at the estigation, in m	given in Part I. 26. Placa of De. Other: 4 \(\) Nursing H njury at Vork? Yes 2 \(\) No ce a time, date and place y opinion, daath occu	24a. Was perfect the second of	Yes 2 No san autopsypomed? Yes 2 No one) idence 6 □Oth how injury occur (Street and Numb wn, Stata) cause(s) and mi date and place, 29d. Date signe	3 Proid 24b. Wave cool of 15 Proid	bably 4 Un lere autopsy find reliable prior to impletion of caudaath? Yes 2 No No No No No No No No No No
fler death. Irector: After this certificate has been signed by the attending In by the funeral director, page 2 should be detached for use a	edical Certification: To Be Completed by Physician/Medical	25. Wes case referred to medicel axaminar? 27. Mannar of Death 1 Natural 5 Panding investig: 3 Suicide 6 Could nedatamine (Check only one)	d. Hospital: 28a. Dat (Mc ation at ba hed buil Physician: To the xaminer: On the and ma	Due to (continue) Due to (continue) Due to (continue) Due to (continue) a of figury a of figury and figury	OF ETENT or as a consequence or as a consequen	ence of): all DOA 28c. tr M 28c. tr 1 et, factory, office occurred at the estigation, in m	given in Part I. 26. Place of De. Other: 4 Nursing Hard Nork? Yes 2 No	24a. Was perfect the second of	Yes 2 No san autopsypomed? Yes 2 No one) idence 6 □Oth how injury occur (Street and Numb wn, Stata) cause(s) and mi date and place, 29d. Date signe	3 Proid 24b. Wave cool of 15 Proid	bably 4 Un lere autopsy find reliable prior to impletion of caudaath? Yes 2 No No No No No No No No No No



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 608 CHATHAM 28 VIRGINIA Deptembel 2000 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Undar 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplaca (State or Foreign **Funeral** Days Months 10 M 20 F Hours 84 218-05-8967 JULY 6,1916 MARYLAND Director Usual Rasidence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10e. State 10b. County 1 Yes 2 No Directo 28s-f MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? TRUST DR C 5183 SHARPS POINT RD 21801 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yas 2 🖾 No If Yes, Give 1 ☐ Nevar Married 2 ☐ Married 21215-0020 ð 1 Yes 2 No Specify: Specify: à 3 ☑ Widowed 4 ☐ Divorced WHITE Year or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER GARMENT COMPANY Maryland 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental JOHN A. PARKER MILLIE BETTS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health a vot. If Item 27 is CHATHAM - NEPHEW 28079 RIVERSIDE DR. EXT. SALISBURY, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Data 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Important: I any injury o 10/2/00 SHAD POINT CEMETERY SHAD POINT, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee 22. Name and Addrass of Facility 705 E. MAIN ST. Deur Kenz SALISBURY, MD 21804 BOUNDS FUNERAL HOME, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** CARDIO PULMONARY ARREST Immediata Causa (Final diseasa or condition rasulting in death) /Medical Examiner Due to (or as a consequence of): MTOCARDIAL INFARCTOON Examiner ACUTE physician and the burial-transit Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Lasf Dua to (or as a consequanca of): USe as t 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yss 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to Completed completion of ceuse of death? this certificate has 1 Yes 2 No 1 ☐ Yas 2 No of Vital 25. Was cese raferred to medicel axaminar? Certification: To Be 26. Place of Death (Check only one) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 200 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Division Attending 5 Pending investigation 1 Natural deeth. 1 Yes 2 No 2 Accidant birector: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicida 28e. Place of Injury - At home, farm, streaf, factory, office building, etc. (Specify) 4 Homicide 6

1968-50-

Chatham

State

within 24 hours a To the Funeral C completely filled To the Hospital

edicai

29a. Certifier

29b. Signature and titla of certifier

KAMESA

31. Date filed (Month, Day, Year) SEP 2 9 Registrar

DHMH 16 Rsv 6/95

M.O.

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

AgaINAI

2000

savisouly ms 21801 IRMO

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

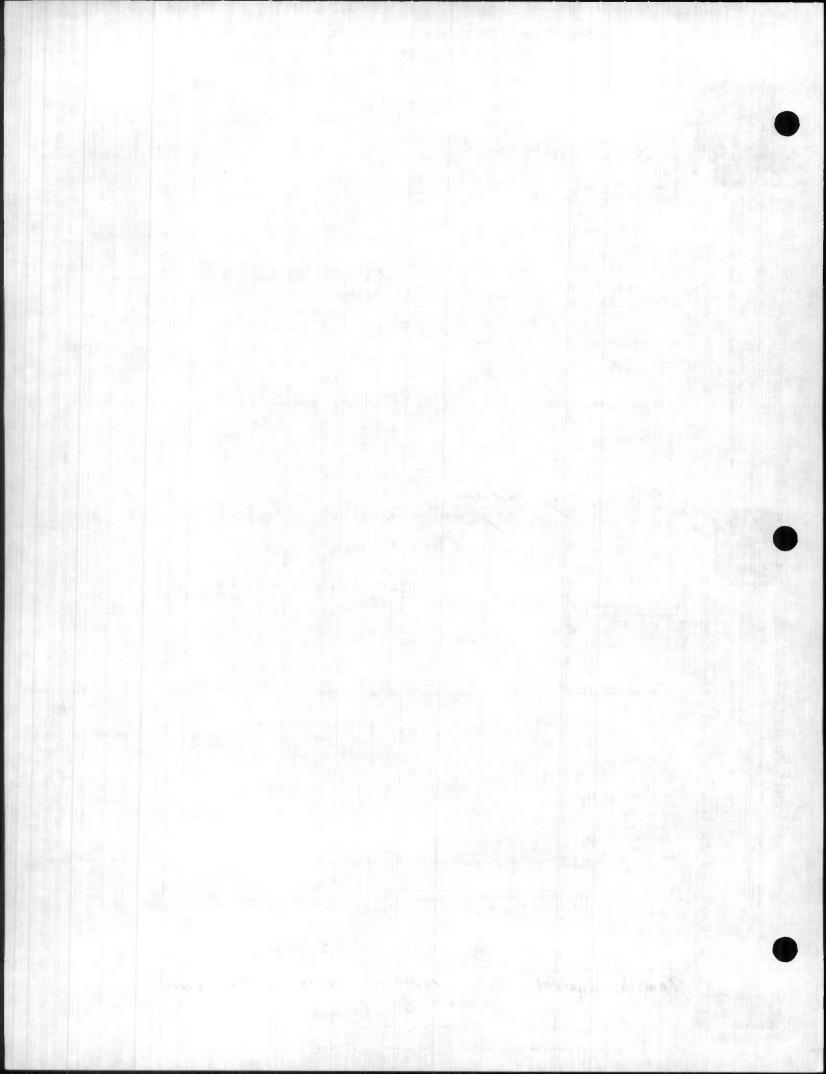
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 54807

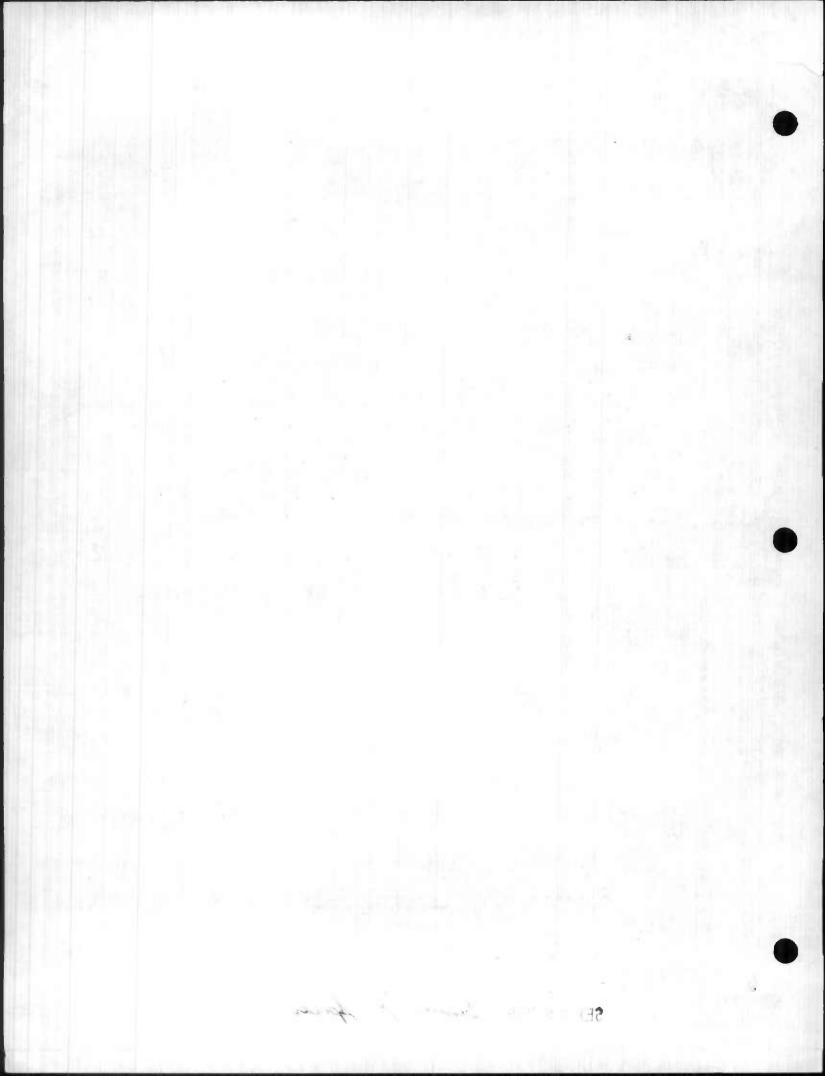
29d. Date signed (Month, Day, Year)

09-28-00



State of Maryland / Department of Health and Mental Hygiene 3223

				Ce	ertificate o	f Death		Reg.	No.	C fine Line U I
Physic	ian	1. Decedent's Neme (First, Middle, Las		3D T D E D			Moi		Dey Yee	
/Medi				CRIDER		th Ch. Tou			27 2000	9:25 a.m
Exami	ner	4a Facility Name (If not institution, give 8208 E Street	street and number)				n, or Location of Deake Be		4c. County of De	eeth
		5. Social Security Number 6. So	x 7. Age (In	yrs. last birthday) If Under 1 Yea		4 Hrs. 8 Det	e of Birth	Calvert	Birtholace (State or Foreign
Funeral Director	ı		XM 2□ F 71		Months Dey	s Hours	Min (Ma	hith, Day, Ye Ly 22,	1929 T	Birthplace (Stete or Foreigr Country) Virginia
yland W		10a. State 10b. County	100	c. City, Town or I	ocation					10d. Inside City Limits
Man	tor	Maryland Calvert				Chesape	eake Bea	ach		1 X Yes 2 □ No
after death with the Marylan or Heme 23e or 28e-f show in her mail be notified at	Director	10e. Street and Number	NE LENGTH		10f. Zip Code)		10g.	Citizen of Whet	Country?
th wil	al	8208 E Street				20732			USA	
8 8	Funeral	11. Merital Status	12. Wes Decedent Ever Armed Forces?	in U,S. 13	Wes Decedent o	f Hispanic Orig	in? (Specify Ye Puerto Rican, e	s or No- etc.)	14. Race - Ar Bleck, W	merican Indien, hite, etc.
hours after death with the Maryland tural; or flems 23s or 28s-f show at Examiner must be notified at	by	1 ☐ Never Merried 2 ☒ Merried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1□ Yes 2NN					white
n 72 hours "natural",	Completed	15. Decedent's Ed (Specify only highest grad		16a. Dec	edent's Usual Occ e kind of work dor	upation	of working	168	b. Kind of Busines	ss/Industry
within then "	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	red)	o			
e filed w al Hygier other th		12		engi	neer					overnment
S da b	Be	17. Father's Name (First, Middle, Last) John Henry	Crider			Haze]	's Neme <i>(First</i> ,	<i>міддів, маі</i> leta	den Sumeme)	Ritchie
0 2 m	2	2								
U 40 4 4	7	19e. Informent's Neme/Relationship (7			ling Address (Stre					
Healther The		Mrs. Marilyn E. C			E. St.,	BOX 3	, unesa	-	Beach, Location - City	
		1 Burial 2 X Cremetion 3 4 Donation 5 Other (Specify	Removal from State	cemetery, cre	itan Cre		9-28-		lexandr	
permit. Peges Department of Important: If any Injury or DOCS.		21. Signeture of Funerel Service Licent	B000		22. Name end Add ausch Fu			.A.,	Owings,	MD 20736
_		23a. Pert1. Enter the disease, or comp shock, or heart feilure. List only of	lications that caused the	death. Do not er	nter the mode of d	ying, such es c	ardiac or respir	etory errest		Approximete
Physician		shock, or heart fellure. List only o	ne cause on each line.							Onset and Death
/Medical	Н	Immediate Cause (Finel	Aden	+ CANI	Makana	0/11	11/1			17 uve
Examiner		disease or condition resulting in death)	o. Squam	to for as a conse	equence of):	100	ve g t			7-3
7 2	ě		Sandry	was De	11 can	uine	o la	ron	186	
nd trans	am	Sequentially list conditions,	b. Due	to (or es e conse	equence of):		1	-	-	
e axe urial-	ũ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
ertificate be executed ling physician and a as the bunel-transit	edical Examiner	that initieted events resulting in death) Last	Due	to (or es e conse	quence of):					194
E = m	3		d.							1
death certifie attending ad for usa a	lan									
that the death ce ned by the attend of detached for us	Physician	Pert II. Other algnificant conditions co	ntributing to death but no	t resulting in the	underlying cause	given in Pert I.	23	b. Did toba	cco uaa contribi	ute to the cause of death
that the detact								Yes)2□ No 3□	Probably 4 Unknow
0 00	1 by				In the second		24	a. Wes en a	utopeu 24	b. Were eutopsy findings
	Completed						24	performe		evailable prior to completion of cause
S 8 CI	du			187-1					(3)	of deeth?
ysician: The law is cartificate has b director, page 2 s								1 🗆 Yes	(2Ng)	1 Yes 2 No
Physician: this cartific ral director,	Be	25. Wes case referred to medical examiner?	Hospitat:		_	Wher:	of Deeth (Chec			
Phys ral di	: To	1 Yes 20116	1 L. Inpatient	2 ER/Outpatie	INT SLI DOA	4 LI NUI	sing Home 5		6 □Other (S injury occurred	ipecity)
After funa	tlon	5 Pending	28a. Date of Injury (Month, Day Yea	ar) Injury	N N	ork? □Yes 2□N		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	mijory occurrou	
deat ctor: y the	Certification:	3 Suicide 6 Could not ba	28e. Place of Injury -	At home, ferm, s				cation (Stree	et and Number or	Rural Route Number,
after Dira	ir.	4 Homicide determined	building, etc. (S)	pecify)			City	y or Town, S	Stete)	
To the Hospital or Attanding Phys within 24 hours after death. To the Funeral Diractor: After this completely filled in by the funaral di	edical C	29a. Certifier (Check only one) 2 Medical Exam	sician: To the best of my iner: On the basis of examinand manner steted.	knowledge, dea minetion and/or i	th occurred et the	time, date and y opinion, deeth	place, end due n occurred et th	to the ceus e time, dete	se(s) end menner end plece, and o	es stated. due to the cause(s)
ithin of the complex	Me	29b. Signeture and title of certifier	and manner stelled.		29c. Lice	nse numbar		29d	Dete signed (Ma	onth, Day, Year)
E ≥ E 8		DOT MAK	- when	M		1 80	026			3-00
		20 Mars 4	www.		P. Lui	U V 9	7 20			0 0
6		30. Name end eddress of person who c								
		J. Michael Brook 31. Dete filed (Month, Day, Year)	S, M.D. Pri		derick,	MD				
Sta Regist		SEP 2 8		neva	D 4	rocks				

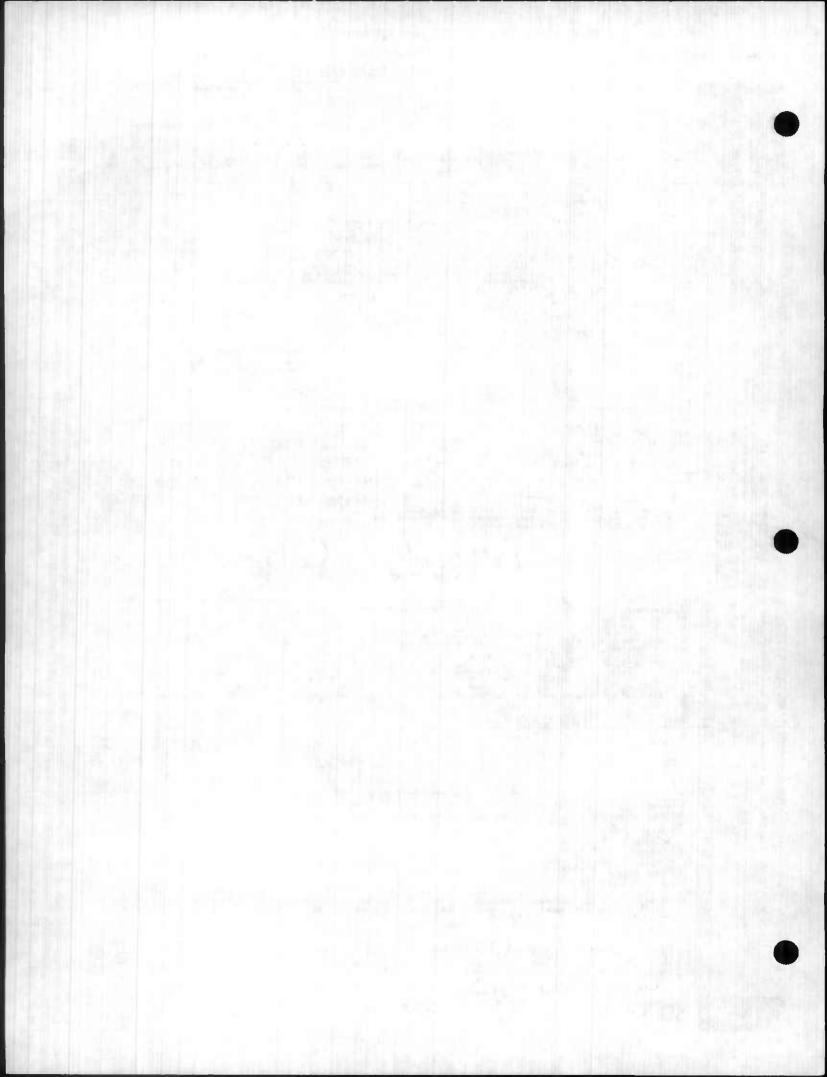


State of Maryland / Department of Health and Mental Hygiene UU

RALPH D. DAVIS Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** SEPT. 21, 2000 Davis 1846 PM Ralph D. /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner MALCOLM GROW HOSPITAL A.A.F.B. PRINCE GEORGES H Undar 1 Yaar H Undar 24 Hrs. 8. Data of Birth (Month Day. Year) 9. Birthplece (State or Country) 192 Clinton, Il 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 10M 20F Yrs. 71 Director 321 20 4875 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits piene. • than "natural", or flama 23a or 28a-f show the Medical Examinating the motified at P.G. 1 ☐ Yas 2 No MD Director Upper Marlboro 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code United States 20772 9115 Marlboro Pike Lot 62 Funeral filed within 72 hours efter deeth 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1XX as 2 No If Yes, Give Yeer or Detes: 1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify. Specify by White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Boatsmin's Male Second Class U.S. Navy 12 other t 18. Mother's Neme (First, Middla, Maidan Sumame) 17. Fether's Neme (First, Middle, Last) Peges t and 2 should be nent of Health end Mentel Ralph Wick Davis Nellie May Gandy 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) . permit. Peges t and 2 Department of Heelth e Important: If Item 27 is any injury or other tracence. 9115 Marlboro Pike Lot 62, Upper Marlboro, MD 20772 Dorothy Davis (WIFE)
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Sept 26 Pate2000 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 22. Name end Address of Fecility Lee Funeral Home, Inc 6633 Old 21. Signeture of Funeral Service Licensee Alexandria Ferry Road, Clinton, Maryland 20735 23a, Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate Intervel Between Onset and Deeth **Physician** eds vosular liseure Immediate Cause (Final disaesa or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immadiete cause. Enter Underlying Cause (Diseese or Injury thet initieted events rasulting in death) Lest Dua to (or as a consequance of) as the buriel-tren signed by the attending physician d be detached for use as the burie Box 68760. Dua to (or as a consequence of): Division of Vital Records. P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Ware autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? this certificate hes Yes 2 No Yas 2 No the Hospital or Attending Physician: thin 24 hours after death. Be 25. Wes case referred to medical 26. Piece of Deeth (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ¥ Yas 2 No 28d. Dascribe how injury occurred Medical Certification: 27. Manner of Death Injury at Work? Affer 1 Neturel 2 Accident 5 Pending Injury 1 Yes 2 No Investigetion Director: / 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Direcompletely filled in b 29n. Certifie 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of exemination and/or invastigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) and menner steted. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signa O.C.M.E SEPT. 22, 2000 eddress of person who completed cause of deeth (Item 23a) (Type, Print) IND 111 Penn Street, Baltimore, Maryland 21201 32. Registrer Signeture State

Registrar



State of Maryland / Department of Health and Mental Hygiene 32233

				Ce	rtificate o	t Death	7		Reg. No.		
Dhoraician	1. Decedent's Name (First, Min	ddle, Last)						2. Data of Dec		Vear	3. Tima of Death
Physician /Medical	ZENOBIE		DAVIS	JR.				Sept.	25°, 200	00	6:18 p.m.
Examiner	4a Facility Nama (If not institu FutureCare-I	tion, giva street and n Pineview	number)				own, or L	ocation of Death	4c. County		rges
Funeral Director	5. Social Security Number 578-70-9528	6. Sex 1X M 2 F		yrs. last birthday) 49 Yrs.	If Under 1 Ya Months Day		Min.	8. Dala of Birt (Month, Da Apr. 2	, Year 1951	9. Birthp Cour Nash	olace (Stata or Foreign County, NC
2 .	Usual Residence of Decedant		140	05 T							
with the Marylan a or 28a-f show Lib notified at Director	Md. P1	my cince Georg		Clinto							10d. Inside City Limits 1√2 Yes 2 No
ter death with the Maryla terms 23e or 28e-f shor ther must be notified at funeral Director	10e. Street and Number 9106 Pineview	/ Lane			10f. Zip Code	0735			10g. Citizen of V		ntry?
	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Divorce	Armed F	2 No		Was Decedent of If Yes, specify C			pecify Yas or No Rican, alc.)		e - Americ ck, Whita,	
Pour Pour Pour Pour Pour Pour Pour Pour		lent's Education	Dates:	16a Daca	dent's Heust On	runation			16b. Kind of B	usinaes/In	dustry
od within 72 ho ygiene. we then 'natur t, the Medical.	(Specify only hig Elementery/Secondary (0-12	hest grade completed	(1-4or 5+)		dent's Usuat Oci kind of work do DO NOT use ret ailable	ne during mo ired)	st of work	king		vaila	
Maryland 21215-0020 32 should be filed within 72 hours at hand Mental Hygiene. The marked other than "natural", or traumatic event, the Medical Exam To Be Completed by I	17. Father's Nama (First, Midd Zenobie Day							e (First, Middla,		na)	
and who	19a. Informant's Name/Ralatio	onship (Type, Print)			ng Address (Stre				er, City or Town,	Stata, Zip	Coda)
M, Manda	Bertha Davis	(Mot	ther)	3007	Brinkl	ey Sta	tion	Dr. Te	emple Hi	ills,	Md. 20748
Pages 1.	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other			b. Place of Dispo cemetary, cre Forest H	matory or other I	Mace)		Data Oct 2,	Clin		
Balti Permit Departs Imports any inju	21. Signature of Funeral Servi	ce Licensee		2	2. Nama and Ada acon Fu	dress of Faci	lity		3447 14	th S	t., N.W.
G-	23a. Part1. Entar the disease,	or complications that			lar the mode of o	lying, such a	s cardiac	or raspiratory ar		ton,	D.C. 20010 Approximata
Physician /Medical	23a. Part1. Entar the disease, shock, or heart failura. L	ist only one cause on	aach line.	10	4					1	Intarval Between Onset and Daath
Examiner	diseasa or condition rasulting in death)	a	Due:	to (or as a conse	1.0	rym	mu			I I	
executed in and intransit	Comments the state on addition	b	Due	to (or as a conse	mence of).					1	
	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events	с		Anox of for as a consec	ia					1	
OX 6876(n certificate be anding physicia use as the bu	resulting in death) Last	d. Pass	He	Embo	1. 1.	there	18d	brosis			
O # # 5 -	Part II. Other significant cond	Itions contributing to	death but not	resulting in the I	ndarhing cause	given in Part	14	23h Did	lohacco usa co	ntribute to	o the cause of death?
ds, P.O. Bo		Hx.							Yes 20010		bably 4 Unknown
I Records, P.O. The law requires that the late been signed by the page 2 should be deteched.			h	noxic Her	nin Co	منف		24a. Was perfo	an autopsy rmed?	av	ara aulopsy findings railable prior to emplation of causa
			A	phasi	2			10	ras 21 No	of	death? □ Yas 2□ No
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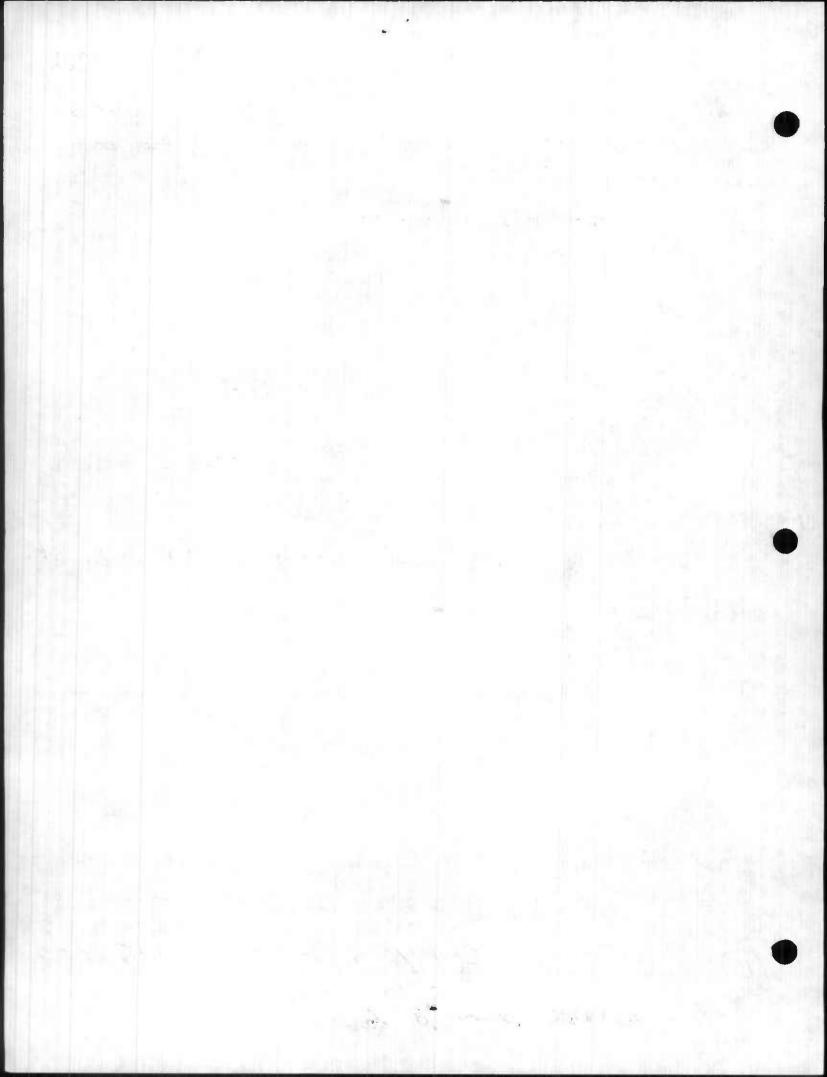
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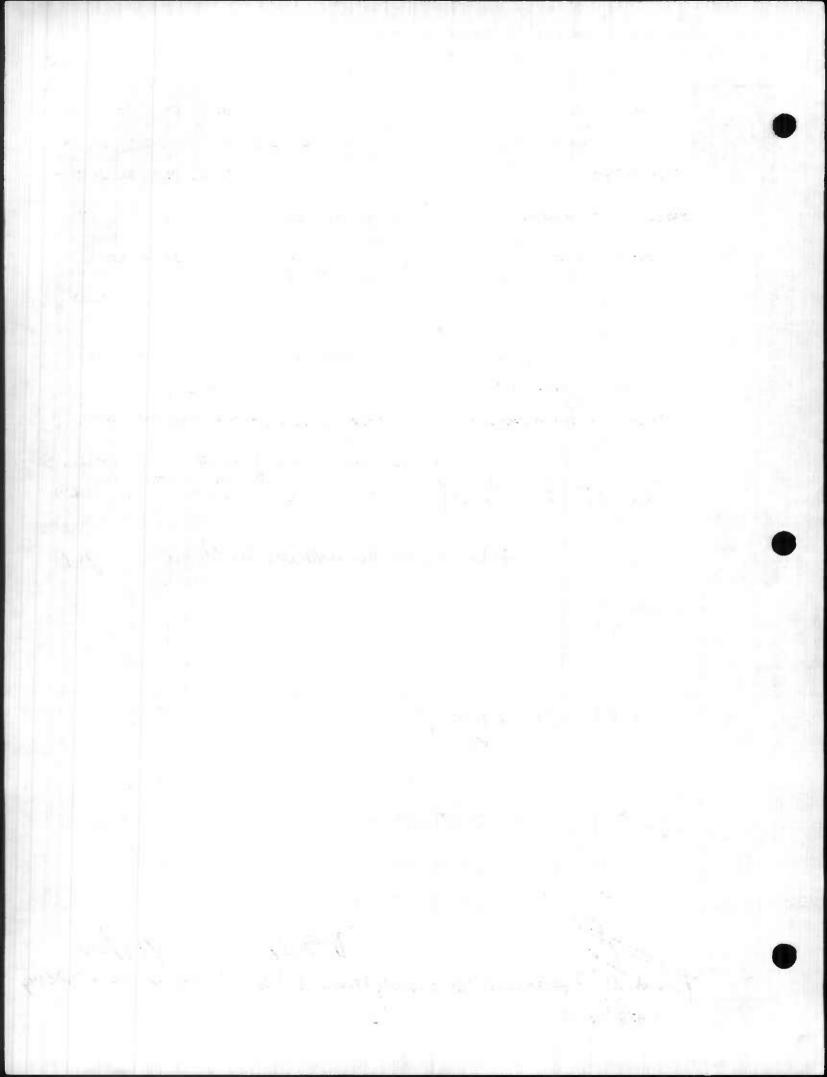
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1 Yas 2 No 1 Inpatient 2 WER/Outpatient 3 DOA 1 Aursing Homa 5 27. Manner of Deeth 28a. Data of Injury 28b. Tima of Injury 28c. Injury at 28d. Das 2	(only one)		
27. Manner of Deeth 28a. Data of Injury 28b. Tima of Injury 28c. Injury at Work? 28d. Das 28d	Residence 6	Other (Speci	ity)
3 Suicida 4 Homicida 6 Could not be datarmined 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 29a. Certifier Check only 29b. Medicat Examiner: On the basts of axamination and/or invastigation, in my opinion, death occurred at the and mannar stated.	scribe how injury o	y occurred	
29a. Certifier Control of the con	ation (Street and to or Town, Stata)		ral Routa Number,
64 2	to tha ceusa(s) and time, date end pl	and manner as place, and dua	stated. to tha causa(s)
29b. Signature and title portifier 29c. Signature and title portifier	29d. Data s	a signed (Month)	Pay, Year)
019431	9	7/18/	w
30. Name and address of laction who complated cause of death (Item 23a) (Type, Print)		1001	

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Beg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death 27,2000 Month **Physician** DIXON WALTER ALOYSIUS September 3:30 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown | Houndar 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplaca (State or Foreign Months | Days | Hours | Min. | April 19,1904 | Washington, D.C. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Director 578-05-2288 96 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits e filed within 72 hours after death with the maryners at Hygiene.
I other than "natural", or flerna 23e or 28e-f ahow
vent, the Madical Examiner must be notified at 1 Yes 2 No Directo MARYLAND ST. MARY'S DRAYDEN 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 45810 BOOTH ROAD 20630 U.S.A. 12. Was Decedent Evar in U,S, Armed Forces? 1 ☐ Yes 2 [M] No If Yes, Give Year or Dates: 14. Race - American Indian, Biack, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White À 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Meat Processer Food permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If fleen 27 is mented other any Injury or other trauments traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Alice Virginia Grimes Walter Edward Dixon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LLOYD G. DIXON - BROTHER 45810 BOOTH ROAD, DRAYDEN, MARYLAND 20630 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Dis 20c. Location - City or Town, State 1 Burial □Cremation 3 □Removal from State 5 Other (Specify) CEDAR HILL CEMETERY, OCT. 2, 2000, SUITLAND, MARYLAND 4 Donetic 21. Signatury THE HUNTY FUNERAL HOME, INC. M00053 P.O.BOX 156, WALDORF, MARYLAND 20604 G. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a confi Box 68760. icate be Physician/Medical 88 980 Po ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. been signed by should be datac 1 Yes 2€No 3 Probably 4 Unknown by Division of Vital Records. 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed Dage 2 certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No uneral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After ours after deep. 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral DI completaly filled in edicai 29a. Certifier 127 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and many her stated. (Check only one

Registrar **DHMH 16 Rev 6/95**

State

29b. Signatura and tifle of certifier

31. Date filed Month, Day, Year)

30. Name and add

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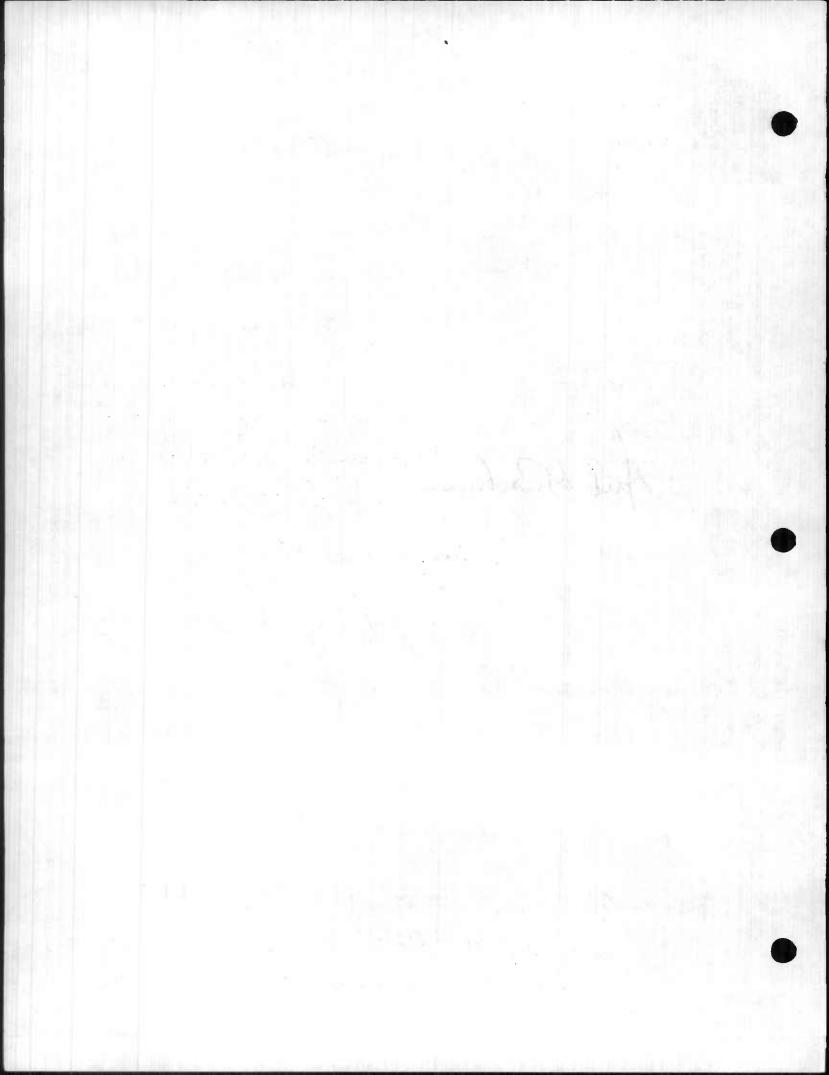
(cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture

29c. Licensa numbe

JARBOE, M.D., 24035 Three Notch Road, Hollywood, Maryland 20636

29d. Date signed (Month, Day, Year)



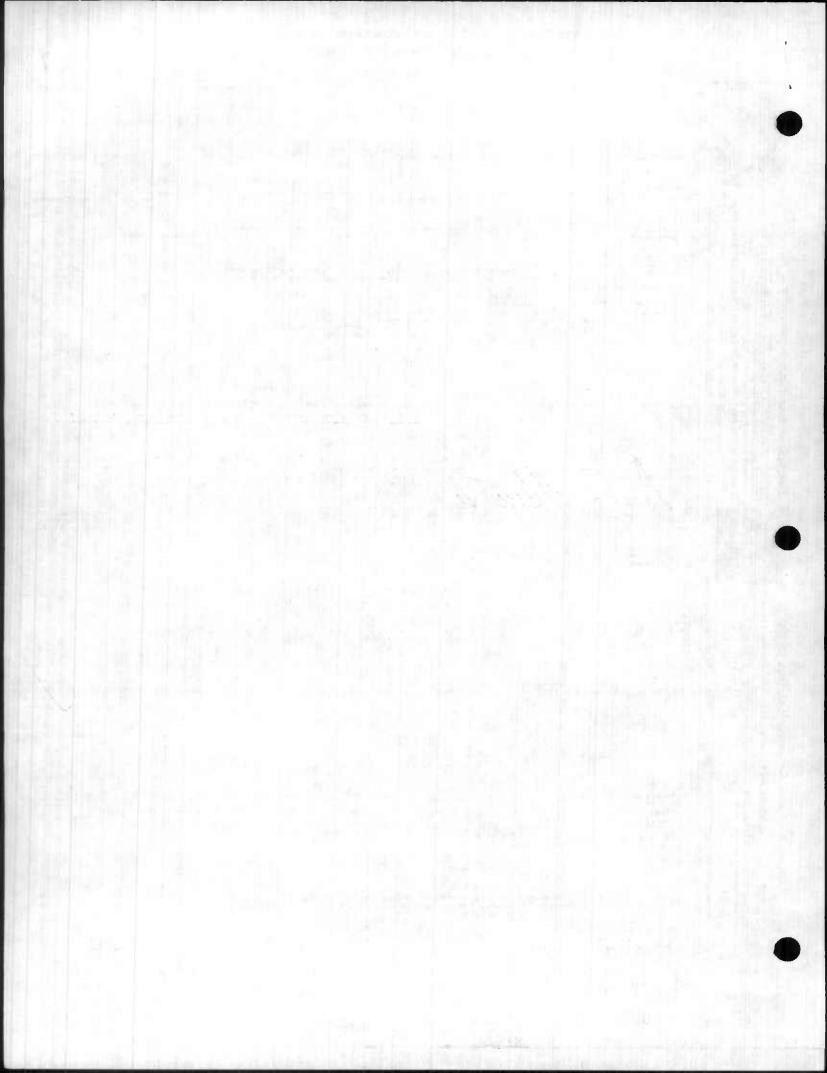
State of Maryland / Department of Health and Mental Hygiene Amend Item 18, 10/2/00, bam, Cecil Co.

1. Decedent's Name (First, Middle, Last) Certificate of Death 2. Dete of Deeth Month Dey Year September 29, 2000 Physician Rosalie Maddelena Downer 10:35 am /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Brightview Assisted Living Harford Bel Air If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Days Min. 1□M 2X F Months Hours 218-54-1387 85 March 17,1915 Director Massachusetts Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Health and Mentel Hygiene. In 27 is marked other than "natural", or flems 23s or 28s-f shoother trisumatic event, the Medical Examples must be notified at 1 XYes 2 No Maryland Harford Havre de Grace Directo 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 659 Alliance Street 21078 U.S.A. Funeral death Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Merital Stetus Was Decedent Ever in U,S. Armed Forces? 72 hours after 1 ☐ Yes 2√ No If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3XXWidowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Destruit. Pages 1 and 2 should be filed within 72 in Department of Health and Mentel hygiene. Important if lise 27 is marked other than any injury or other traument. 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Twelve Years Homemaker Personal Residence 18. Mother's Name (First, Middle, Maiden Symeme) Antonina Zammuto 17. Father's Neme (First, Middle, Last) Carlo Buscemi Anntonina Sumuto 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Robert C. Downer (son) 1511 SUPERIOR STREET, HAVRE DE GRACE, MD. 21078 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriet 2 Cremetion 3 Removel from Stete Harford Memorial Gardens 10/2/00 Aberdeen, Maryland 4 ☐ Donetjon 5 ☐ Other (Specify) 22. Name and Address of Fecility
Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service Licent 21903-0766 Perryville, Maryland plications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner DIMONIAN 6B5Muchus The law requires that the death certificate be axecuted been signed by the ettending physician end should be detached for use as the bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e conseguence of): Box 68760. P.O. 23b. Did tobacco use contribute to the cause of chath? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Onknown Division of Vitai Records. g 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? page 2 should Completed certificate has 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this nours efter death.

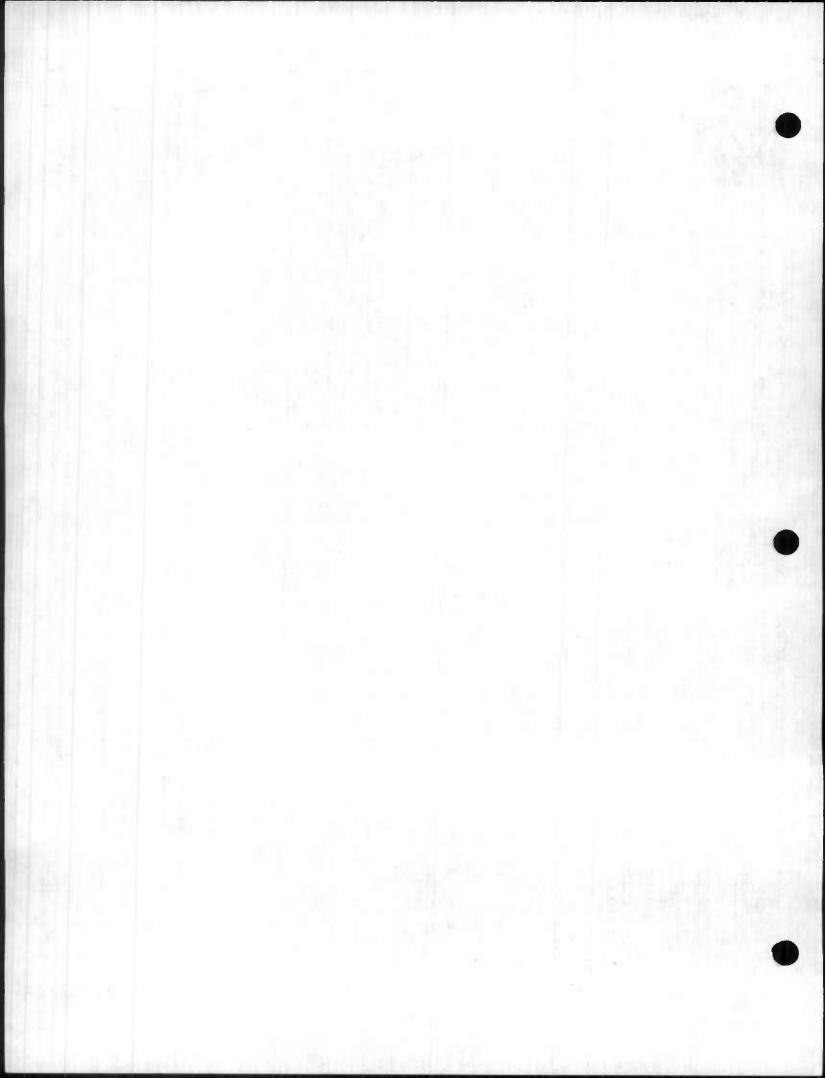
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| Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29c. License numbe 29d, Date sigsed (Month, Dev. Year) 29b. Signature and title of certifie 150 12 erson who completed cause of deeth (Item 23a) (Type, Prifit) 6 32. Registrar's Signature 31. Date filed (A onth, Dey, Year) State Registrar

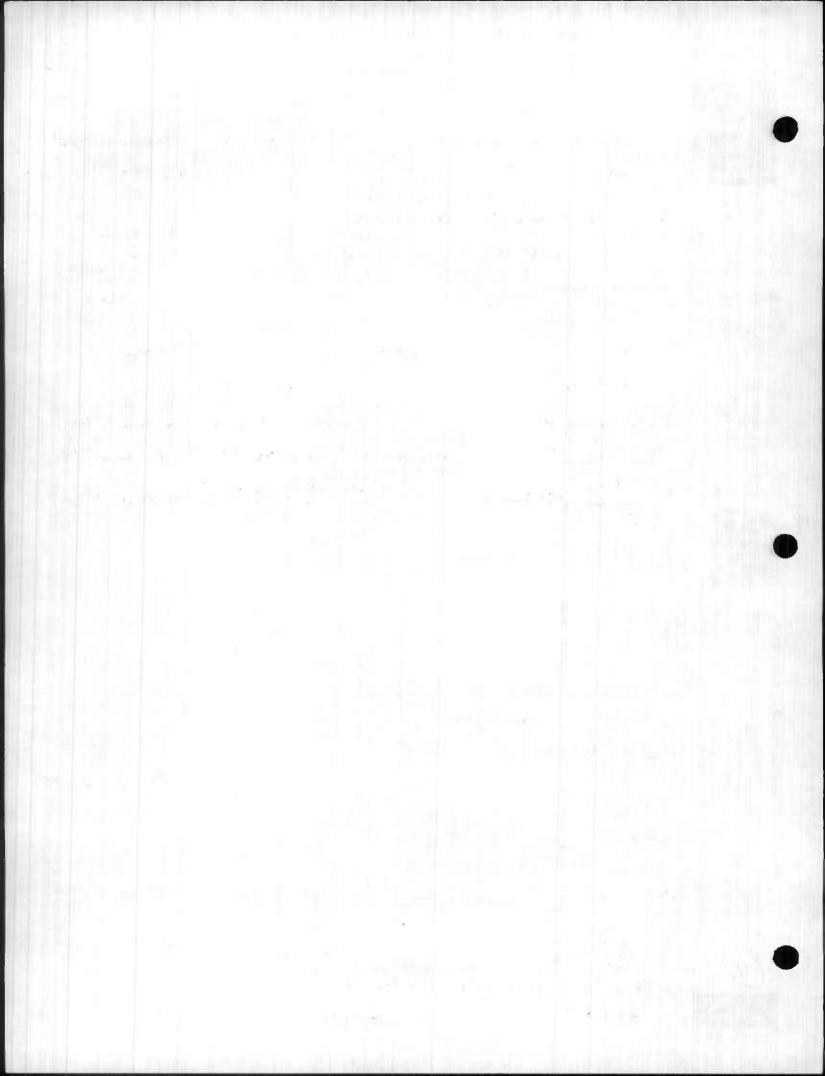
DHMH 16 Rev 6/95



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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death **Physician** SEPTEMBER 20, 2000 BEONIA FRANCES EDMONDS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner Doctors Community Hospital Lanham Prince George's If Undar 24 Hrs. Hours Min. If Under 1 Yaar 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** Days 1□M 20 F Months 72 Director 248-38-5420 August 27,1928 South Carolina Usual Residence of Deceden with the Maryland 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits must be notified at Maryland Prince George's 1⊠ Yas 2 No Director Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6917 Kent Town Drive 20785 or Nema 23a U.S.A. Funeral Poèmit. Peges 1 and 2 should be filled within 72 hours effer deet important: if item 27 is marked other the any injury or other training. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Datas: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married Specify: Black by 1 Yas 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 3 Years Private 18. Mothar's Nama (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Be Naomi Ruth Hynes John Brown 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 2447 Kent Village Place, Landover, Maryland 20785 Alan Way/Son 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 09/27 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Harmony Memorial Park 4 ☐ Donation 5 ☐ Othar (Specify) 2000 Landover, Maryland 22. Nama and Address of Facility
J.B. JENKINS FUNERAL HOME 21. Signatura of Funaral Sarvice Licenses Nancu 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disaasa or condition rasulting in death) /Medical TERMINAL Examiner Due to (or es a consequence of): Completed by Physician/Medical Examiner physician and the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Box 68760, Dua to (or as a consequence of) for usa as Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Chromi Rend Insuffrency 24b. Wara sutopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Multi infarct Dementes After this certificate has 1 Yas 2 □ No 1 ☐ Yas 2 No tal or Attanding Physician: Traster deeth.

al Director: After this certificat led in by the funeral director, p 25. Was casa rafarred to medicaf examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 █¶npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2♥ No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 1 Natural
2 Accident 5 Pending invastigation 1 ☐ Yas 2 ☐ No 281. Location (Street and Number or Rural Routa Number, City or Town, Stete) 6 ☐ Could not be 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 Suicida filled in by 4 Homicide To the Hospital
within 24 hours
To the Funeral
completely filled Hospital 1 A Certifying Physician: To tha best of my knowledge, deeth occurred et the time, data end place, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and mannar stated. edicai 29a. Certifier (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier D-17874 M. S. Non 9-22-2000 30. Nama and address of person who completed cause of death (ttam 23a) (Type, Print)

State Registrar

31. Data filed (Month, Dey, Year) SEP 2 5 2000

S. M. NAYAR

3717 - 38" AVF MD 32. Registrer's Signeture

DHMH 16 Rev 6/95

EDMONIS

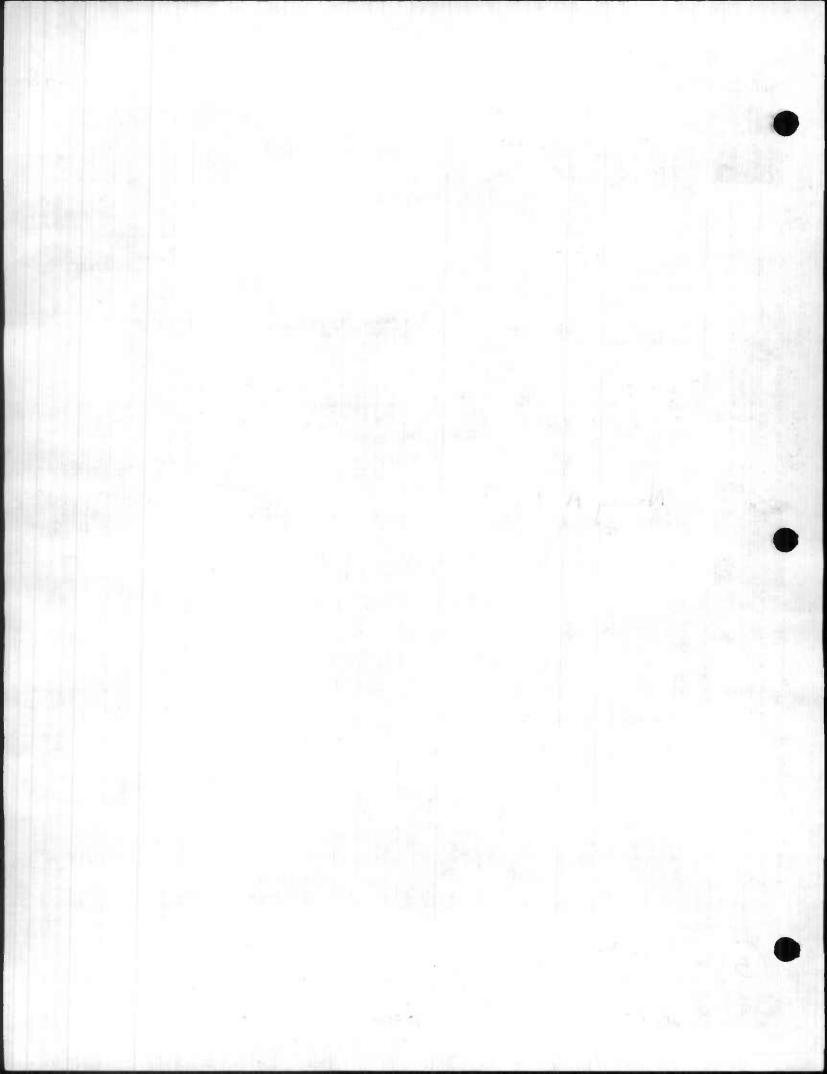
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Division

MD 20722

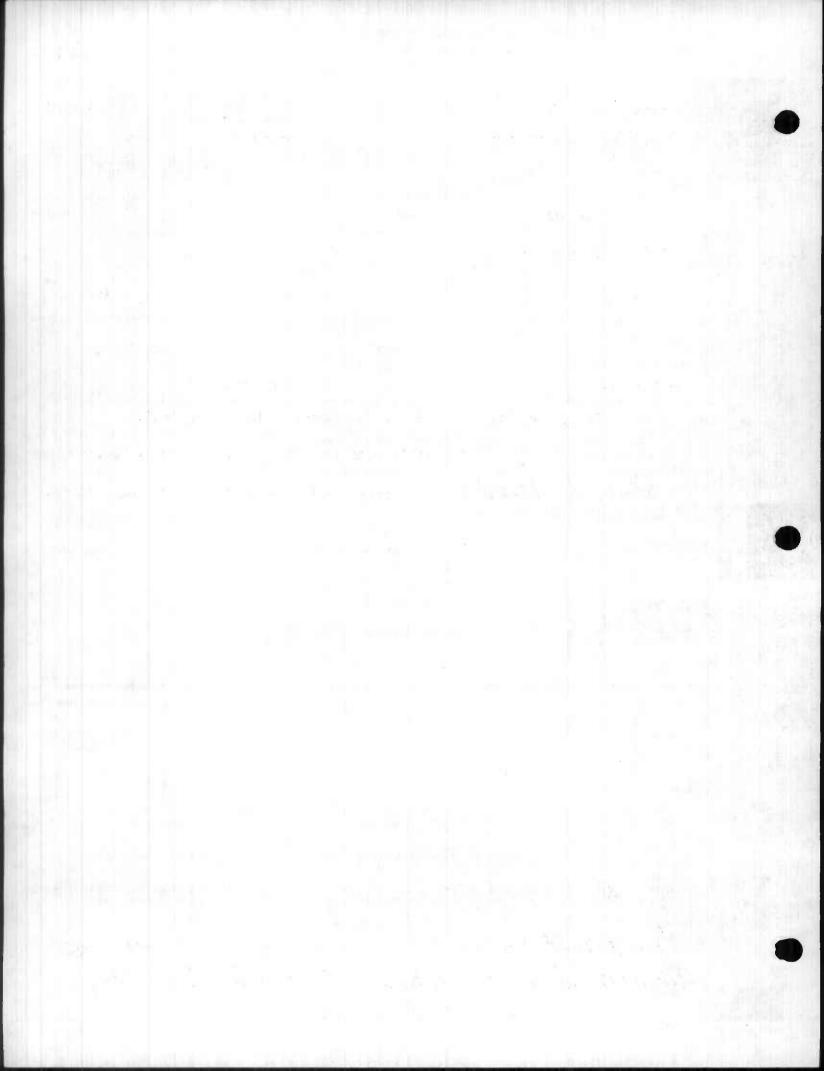
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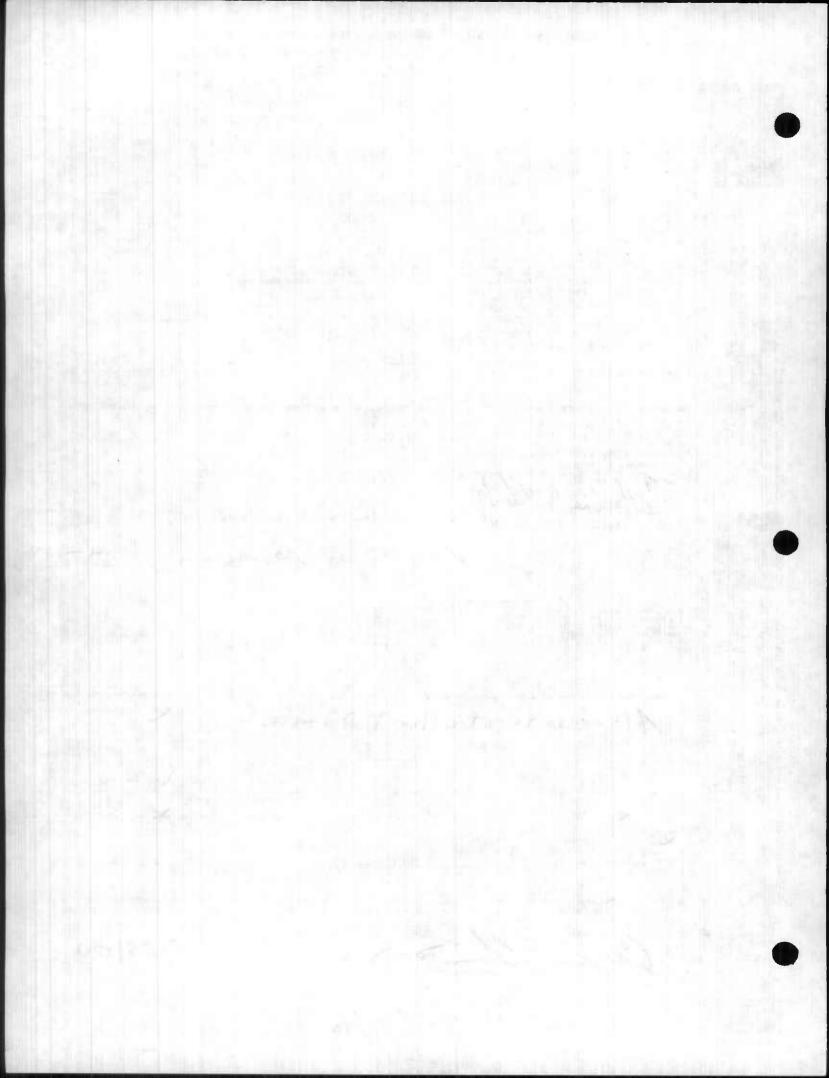
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State of Maryland / Department of Health and Mental Hygien 3 2 2 4 1

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Dhysis	ion	1. Decedent's Name (First, Middle	, Last)			WITT.			2. Dete of D		Yeer	3. Time of Dee
Physic /Medi Exami	cai	Bernice Darlene 4e. Fecility Name (If not institution		ar)			46	. City, Town,	Sept or Location of Dea	. 21	2000	3:25PM
		Westminster Nu	rsing Cent	er			1	Westmin	nster	Ca	rroll	
Funeral Director		5. Sociel Security Number 218–40–7949 Usual Residence of Decedent	6. Sex 7. /	Age (In yrs. las	t birthday) Yrs.	If Under 1 Months D	Year Deys	If Under 24 H Hours M		irth ey, Year) 2,1942	Cour	place (Stete or Foi ntry) 1and
yland		10e. Stete 10b. County		10c. City, 7	Town or Lo	cation					1	10d. Inside City Lir
Mer at	to	MD Carr	011	We	stmin	ster						1 □ Yes 2/□
h with the	Funeral Director	10e. Street end Number 3968 Littleste	own Pike			10f. Zip Co	158			10g. Citizen o	f Whet Cour	ntry?
filed within 72 hours after death with the Meryland Hygiene. Hygiene and the first first first show the than "natural", or flams 23a or 28a-f show out, the Medical Examiner rougher for coming a standard of the first	by	11. Maritel Status 1 □ Never Merried 2 □ Marri 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force ed 1 Yes 2 If Yes, Give / Yeer or Detes	s? DNo		Vas Deceden i Yes, specify		penic Orlgin? , Mexican, Pu Specify:	(Specify Yes or N erto Rican, etc.)		ece - Americ lack, White, city: Whi	etc.
72 ho	Completed	15. Decedent (Specify only highes	s Education		16e. Deced	ent's Usuel C	Occupat	ion uring most of w	vorking	16b. Kind of	Business/Inc	dustry
ithin Ban	ngu	Elementary/Secondary (0-12)	College (1-4o	or 5+)	life. D	OO NOT use I	retired)	ining most or in	rorking			
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d 2 should th end Mer 7 Is marke traumatic	1º	Arthur Selby							e Wentz			
		19e. Informent's Neme/Relationsh							Rurel Route Numi			Code)
		Barbara A.Selby 20e. Method of Disposition	y Daughter			St Bal	-	ore St	Taneyto			
Pages nent of int: If it		1 Buriel 2 Cremetion 4 Donetion 5 Other (Sp		cem	etery, crem	Cemet	r plece,)	9/26/00	20c. Location Silve	er Run	
permit. Depertuine Importa any infu		21. Signeture of Funeral Service L	Louds Louds	0		Neme and A			aple Ave	.Little	stown.	PA17340
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E # 8	Co								10	Yes 2□No	1 🗆	☐ Yes 2☐ No
ician: The	Be	25. Wes case referred to medical exeminer?						26. Plece of D	eeth (Check only	one)		
ing Phys. After this	tion: To	1 ☐ Yes 2 ☑ No 27. Menner of Deeth 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident Investigat	Hospital: 1 Inpat		Outpetient b. Time of Injury		Injury e Work?		Home 5 Res	idenca 6 🗆 O		v)
Dir Oir	Certification:	3 Suicide 6 Could no determine	ed 286. Pieca of It	njury - At home etc. (Specify)	, farm, stre	et, factory, of	ffice		28f. Location (City or To		nber or Rura	al Route Number,
To the Hospital within 24 hours of To the Funeral completely filled	edical	29e. Certifier (Check only one) 12 Certifying 2 Medical E	Physician: To the best caminer: On the basis end menner s	of examinetion	dge, deeth end/or inve	occurred et the estigetion, In I	he time my opir	dete end plea lon, deeth occ	ca, end due to the curred et the time,	ceuse(s) end n dete end pleca	nenner es st i, end due to	eted. the ceuse(s)
To the To the Comp	2	29b. Signature and title of certifier				29c. Li	cense r	number		29d. Date sign	ed (Month, I	Dey, Yeer)
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		30. Na ye end eddress of person w	no completed cause of	deeth (Item 23	le) (Type, P	rint)	1/0	14	0/.	7	7	2000
	7	John W. //Ide	xuton 68	stoole	Koa	d,	VA	1/1001	nster,	ma	1115	/
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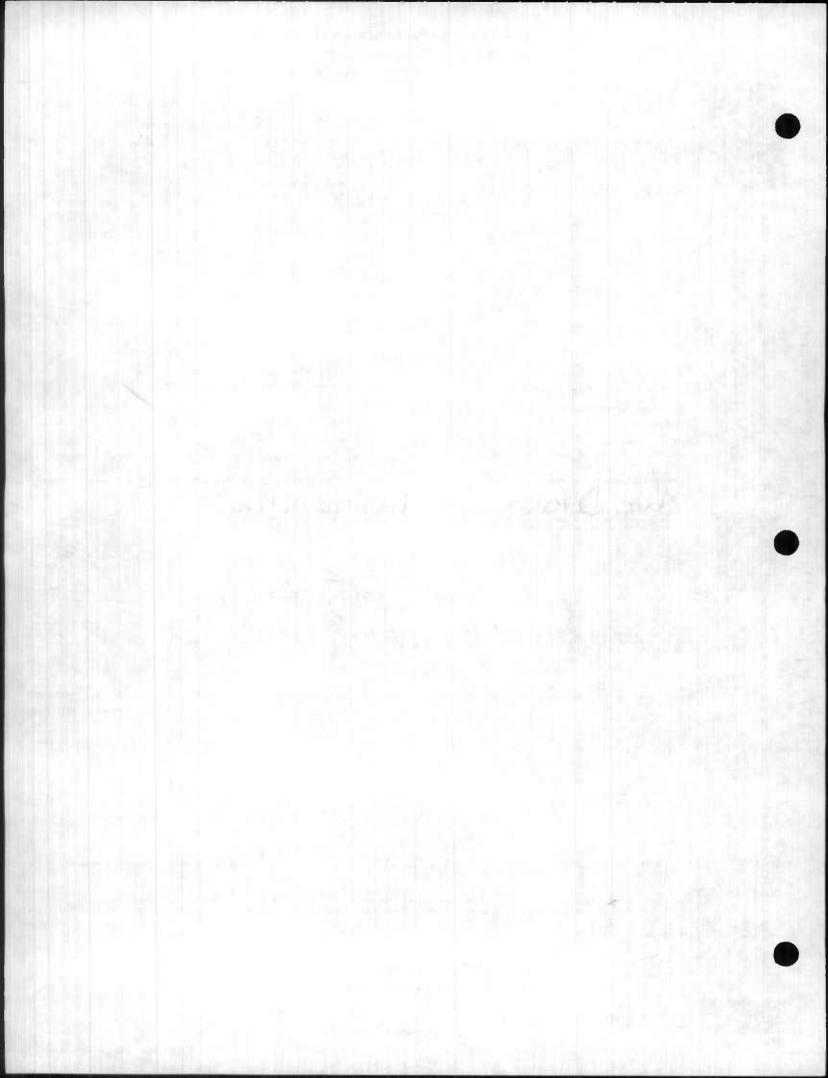


	Certificate of	of Death	R	eg. No.	
	Decedent's Nema (First, Middla, Last)		2. Dete of Deat		3. Time of Death
Physician	Virginia Frances Ecker		Septemb	er 21	2000 3:30PM
/Medical Examiner	4a Facility Neme (II not institution, give street and number) 22120 Foxlair Rd.	4b. City, Town, or L Gaithers	ocation of Death	4c. County of	of Deeth itgomery
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) H Undar 1 Yr 80 Yrs.		8. Dete of Birth (Month, Dev. Sept. 13	, Year) , 1920	9. Birthplece (Stete or Foreig Country) Maryland
Death with the Maryand ms 23e or 28e-f show rmat be notified at	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	loni ole			10d. Inside City Limit
or 28a-1 be notified	1.02 / 20.10	derick			
items 23s or 25s-f showner must be notified at uneral Director	10e. Street and Number 10f. Zip Cool 1227 Danielle Dr.	21701		0g. Citizen ot W	S.A.
ural', or items 23 a Examinet must od by Funeral	11. Marital Status 1 Nevar Married 2 Married 3 \(\text{Midowed} \) 4 \(\text{Divorced} \) Divorced 12. Wes Decedent Ever in U.S. Armed Forcas? 1 \(\text{Yes} \) 2 \(\text{Mon} \) 0 If Yes, Sive Year or Datas: 13. Wes Decedent If Yes, Specify 0 If Yes, Sive Year or Datas:	ot Hispenic Origin? (Sp Cuban, Maxican, Puerto No <i>Specify:</i>	pecify Yes or No- Rican, atc.)		- American Indien, k, White, etc. White
and de	15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Oc (Give kind of work of life. DD NDT use re	cupetion one during most of work tired)	king	16b. Kind of Bus	siness/Industry
Ac the Me	Elementary/Secondary (0-12) Collega (1-4or 5+) homema			own	home
	17. Fathar's Name (First, Middle, Last)	18. Mother's Nem	a (First, Middle, I	Maiden Sumeme	9)
Mental H inhad off its even To Be	Luther Stang	Annie	Summer		
DEE	19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Str			-	
m 27 her tr	Marsha Rist/ daughter 22120 Foxla	ir Rd. Ga	aithersb	urg, MD	20882
unt: If ham ary or oth	20e. Method of Disposition 1 Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Neme of Cemetry, Cremetry or other Linganore Cemetry)	place)	Dete 9/25/00 [City or Town, State
Departiments any inji		iberty Rd.			
requires that the death certificate be executed some signed by the attending physician and should be detached for use as the burial-transit eted by Physician/Medical Examiner	Immediate Ceuse (Final disease or condition rasulting In deeth) Bue to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Influry that initieted avents resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of):				
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ald a	examiner? 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Detail Sea. Dete of Injury 28b. Time of Injury 28c.	Other: 4 Nursing H Injury et Work? 1 Yas 2 No	oma 5 Residence Annual		_{nr (Specify)} residen ed
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within 24 hours To the Funeral completely filled	29e. Certifier (Check only one) ACartifying Physician: To the best of my knowledge, daeth occurred et the control of the basis of examination and/or investigation, in results of the basis of examination and/or investigation, in results of the basis of examination and/or investigation, in results of the basis of examination and/or investigation, in results of the basis of examination and/or investigation, in results of the basis of examination and/or investigation, in results of the basis of examination and/or investigation, in results of the basis of examination and/or investigation, in results of the basis of examination and/or investigation, in results of the basis of examination and/or investigation, in results of the basis of examination and/or investigation, in results of the basis of examination and/or investigation, in results of the basis of examination and/or investigation, in results of the basis of examination and/or investigation, in results of the basis of examination and/or investigation, in results of the basis of examination and or investigation.	e time, dale end place ny opinion, deeth occu	, and dua to the c rred at tha time, d	euse(s) end ma date end pleca, e	nner as stated. and due to tha cause(s)
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s - 0		6428		9/2.	3/00
	30. Neme and address of person who completed causa of death (Itam 23a) (Type, Print)	P1	ala MD O	1701	
	Casper E. Cline III 300 W. 9th St.	rederi	ck, MD 2	1/01	
State Registrar	31. Dete tiled (Month, Day, Year) SFD 9 5 2000 32. Registrer's Signature				



	Same.				716	C	ertifica	te of	Death		Reg. No.		32243
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			m Maryla	no Hosp	ital				Clinton			G.	
	Funeral Director	5. Social Security N 578 14 38	387	Sax 1□M 2∏F	7. Aga (In yrs. 90	. last birthda Yrs.	y) If Unda Months	ar 1 Yaar s Days	If Undar 24 Hrs. Hours Min.	8. Date of B (Month, D Aug 28	irth Year) B, 1910	9. Birth	place (Stata or Foreign The Carolina'
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		MD 10e. Street and Nu 9211 Stu					10f. Z	ip Coda 207	35		10g. Citizen of Unit	What Cour	
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22/C	Departme important any injury any injury	21. Signature of Fu	5 ☐ Other (Specimeral Service Lice		FO				ss of Facility 66	33 Old	Alexand	ria F	erry Road,
590	40240	lun	ellt	cala			Lee !	run			nton, M	D 207	
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	State	31. Date filed (Mon	th, Day, Year)	32. R	egistrar's Sign	natura							

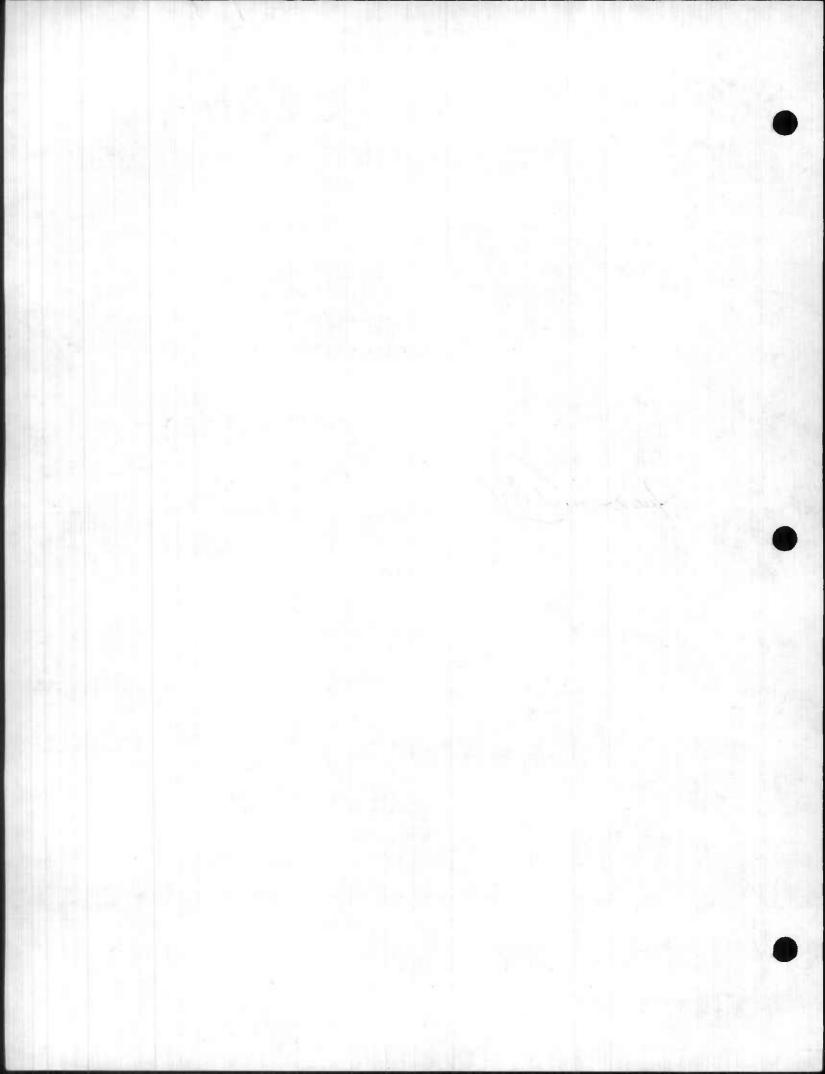
DHMH 16 Ray 6/95



Baltimore, Maryland 21215-0	permit. Pages 1 and 2 should be filed within 72 ho	
	Phy /M Exa	rsic ledi ami
ion of Vital Records, P.O. Box 68760,	nding Physician: The law requires that the death certificate be executed	: After this certificate has been signed by the attending physician and

			Certifi	cate of D	eath		Reg. No.	0 3	2244
Physician	1. Decedent's Name (First, Middle, Las	()				2. Data of De Month	Day	Year	3. Time of Death
/Medical	MAURICE	A	FAIR			9/25/			0514
Examiner	4a Facility Nama (If not institution, give					Location of Deat			
221 12	HOLY CROSS HOSPI 5. Social Security Number 6. Sa		rrs. last birthday)		ILVER S	. 8 Date of Bir	MON		ce (Stata or Foreign
Funeral Director		TM 2DE		onths Days	Hours Min.	12/12/	32	Countr	NGTON, DC
Mand Hand	10a. Stata 10b. County	10c.	City, Town or Locatio	n				100	d. Inside City Limits
Man	MD MONT		SILVER S	SPRING					X Yas 2 No
trer death with the Mai r ferma 23a or 28a-fs direr must be notified Finneral Director	10e. Street and Number 1913 EAST WEST H	IGHWAY	# 204	Of. Zip Code 20910			10g. Citizen of V USA	Vhat Country	y?
urs a urs a	Widowed 4 □ Divorced	12. Was Decedent Evar in Armed Forcas? 1 Armed Forcas? 1 Armed Forcas? 1 Yes 2 No. 18 Yes, Give Year or Datas:	FORCE 1	Decedent of His i, specify Cuban as 2 No	panic Origin? (S , Mexican, Puer Specify:	pecify Yes or No to Rican, atc.)	Specify	e - Americar ck, Whita, at BLA	c.
21215-002 led within 72 hours bygiene. by then "natural", rt, the Medical Ex-	15. Decedant's Edi (Specify only highest grad	ucation de completed)	16a. Decedent's	Usual Occupati	ion uring most of wo	rking	16b. Kind of Bu	usiness/Indu	stry
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S President	17. Fathar's Name (First, Middle, Last)	NONE	COMMUN	ICATIONS			STATE D		AEN I
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Baltimore, Maryland 21, permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: if fem 27 is marked other that any injury or other traumatic event, that once.	20a. Mathod of Disposition	20	b. Place of Disposition camatary, cremetor	(Nama of	1	Data	20c. Location -		
Page ent o	1 Burial 2 Cremation 3 1 Donation 5 Other (Specify		Quantico			Oct.2	Quanti	i co V	0
Partit.	21. Signeture of Funaral Samon Licens	of and a			of Facility TOH	N T. RH	INES CO.	- INC	
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and il-tran	Sequentially list conditions, if any, leading to immediate	Dua t	o (or es a consequenc	se of):					
68/60, ficate be assecuted physician and as the burial-transit	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disaase or Injury that initiated evants	C.	RRHOSIS						
		d. HYPOTHYRO	O (or as a consequance)	e of):					
IS, F.C. BOX es that the death cert igned by the attendin be detached for use by Physician/N						1			
Physic	Part II. Other significant conditions co	ntributing to death but not	resulting in the underl	ying causa giver	n in Part I.		Yes 2 No		he cause of death
	ALCO	HOLIC ABUSE				''	108 21240	3 F1000	ioly 4 🗆 Ollidao
requir requir hould							en eutopsy ormed?	com	e eutopsy tindings lable prior to pletion of cause eath?
						10	Yes 2K No		Yas 2 No
VITAL I	25. Was casa rafarred to medical				26. Place of De	ath (Check only			
_ K 50 C	axaminer?	Hospitel: 1 Inpatient	2 ER/Outpatient 3	□ DOA Other	**		idence 6 □Oth	er (Specify)	
or Attending Physician: The after deeth. Director: After this certificate in by the funaral director, per file after a feether.	27. Mennar of Death 1 Natural 5 Panding 2 Accidant Investigation	28a. Data of Injury (Month, Day Year		28c. injury a Work?	at as 2 No	28d. Describe	how injury occur	red	
LIVISION O Hospital or Attending Ph 24 hours after deeth. Funeral Director: After th stely filled in by the funeral dical Certification: "	3 Suicide 6 Could not be 4 Homicide datarmined	28e. Placa of Injury - A building, atc. (Sp.			(Street and Numb wn, Stete)	per or Rural	Routa Number,		
Hoepital 24 hours Funeral pately filled	29a. Certifier 1 Certifying Phy (Check only one)	relcian: To the best of my iner: On the basis of axam and mannar stated.							
Series A	29b. Signature and title of certifier	0	han Ti	29c. License	number		29d. Date signe	d (Month, D	ay, Year)
1/1	1 Sul	Luga		D48	152		9/26	100	
1/6/	30. Nama and addrass of person who c	omplated causa of death (Item 23a) (Type, Print				, ,		
	SAMUEL A SEME		O FOREST		, SILVE	R SPRIN	G, MD 20	910	
State	31. Data filad (Menth, Day, Year)	32. Registrar's Si	gneture						
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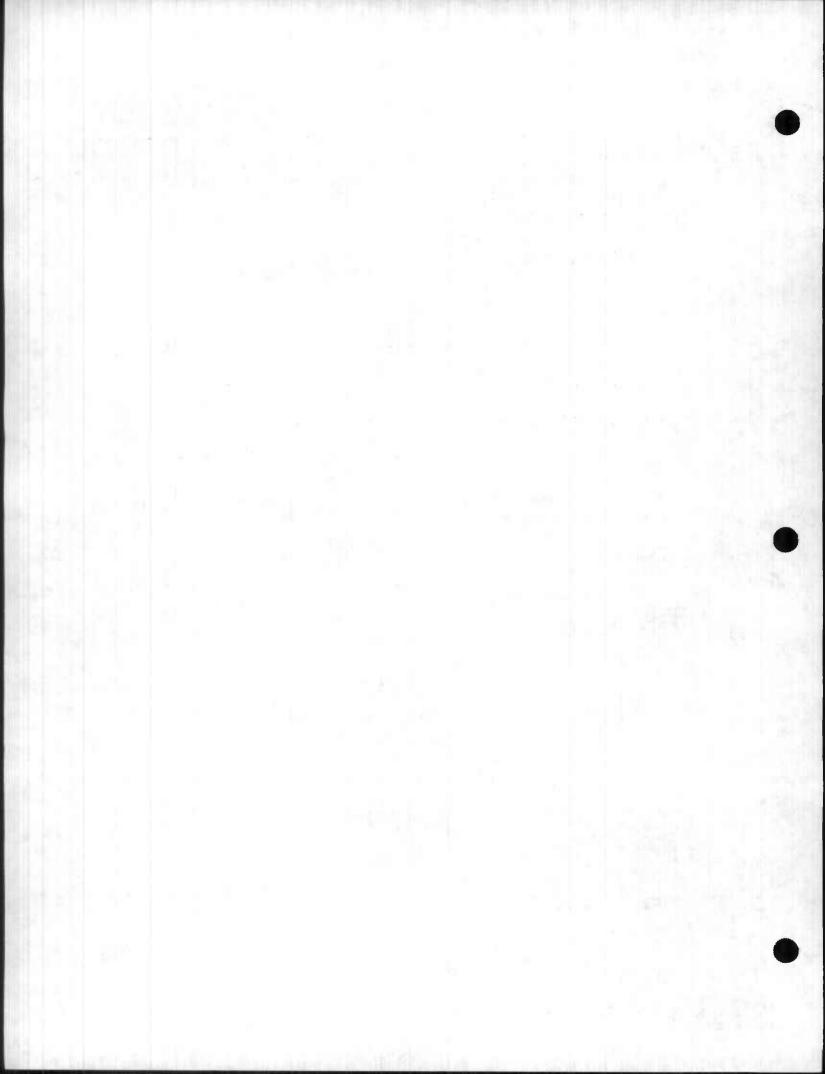
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State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 2 4 5

						Cei	rtificate	of I	Death		Re	g. No.			
	Physicia	an	1. Decedent's Neme (First, Middle,	With the same		E					2. Date of Death Month	Dey	Year	3. Time of D	
Sp.	/Medic	-	4e Facility Neme (If not institution,		tasia	Fontan	illa		th City To	wn or Le	Septemb	er 28		6:40AM	1
	Examin	er	Livingston Heal	-					_						
_				6. Sex		rs. last birthday)	If Under 1 \		If Under		ington 8 Date of Birth	Prince		-	Foreign
	Funeral Director		578-18-8170	1□M 2□F	88	Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day, Sept. 1	Year)	Cour	plece (State or f	A.J
			Usual Residence of Decedent		00		1				bept. I	0,1912	Dail	Imore,	10.
	yland		10a. Stete 10b. County			City, Town or Lo	ocation						1	0d. Inside City	Limits
	Mar	io	Maryland Prince	George's	s Ox	on Hill								1 ☐ Yes 2	No No
	death with the Maryland ims 23a or 28a-f show imstile notited at	i e	10e. Street end Number				10f. Zip Co	ode			10	g. Citizen of V	Vhat Cour	ntry?	
	h wit	0	6439 Livingston	Road Ar	ot. 201		207	45				USA			
	deat	Funeral Director	11. Marital Status		cedent Ever in	U,S. 13.		t of H	lispenic Or	igin? (Sp	ecify Yes or No-	14. Rac	a - Americ	an Indian,	
2	within 72 hours after death with the Marylan ene. Than "natural", or ferma 23a or 28e-f show the Masical Examiner must be notified at	y Fu	1 Never Married 2 Marrie	ed 1 🗀 Yes If Yes, G	2 XIXIo		1 Yes 2√		Specify:		ritoari, oto.)	Specify			
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e e	is 1 and of Heelth Item 27 other to	1	20a. Method of Disposition	Daugiteel	-	. Placa of Dispo	sition (Name	of		-	Date 2	20c. Location -	City or To	own, State	
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	if. P		4 ☐ Donation S ☐ Other (Sp 21. Signature of Juneral Service L		1				-			Brentwo		riu.	
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T.			shock, or heart faiture. List of	nly one cause on	each line.									Intervet Betwee	
	Physician /Medical		Immediate Cause (Final		CTD	DUT	1	V	ult	ple	2, Cer	elolavo	rbank	mon	my
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-	ng P	9	27. Manner of Death 1X□Natural 5 □ Pending	28a. Date (Mo.	of Injury nth, Day Year)	28b. Time o		. Injur Wor			28d. Describe ho	w injury occur	red		
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DIVISION	or Att	Certification:	4 Homicide determine	ned Zoe. Plac	a of Injury - At ding, etc. (Spe	t home, farm, str cify)	reet, factory, o	office			28f. Location (Sti City or Town		er or Hur	al Houte Numbe	er,
2	hours a hours a unersi C by filled		We will											10404	
	工工工工工	edical		xaminer: On the i	basis of exami						end due to the ce red at the time, de				
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	(1)		30. Name end address of person w						11.44	37.	00717				
			Shantha Murthy, 31. Date filed (Month, Day, Year)	(1.D. 01	.90 UXO. Registrar's Şiğ	ii IIIII	na. Ux	on	HILL	. Md	20745				
	Stat	te	SFP 2 8 2000	(Page vin	D	dos	cks1								



State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 3. Tima of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) SEPTEMBER 29, 2000 **Physician** ALICE KIRSTEN **FUESE** 10:15 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) **Examiner** CHARLES COUNTY NURSING & REHAB. CENTER CHARLES LaPLATA H Under 1 Year If Under 24 Hrs. 8. Deta of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthpleca (Stata or Foreign Country) 10M 2XF **Funeral** 91 Yrs. VIRGINIA 577-28-3561 **Director** Usual Rasidance of Dacedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Fage: 1 and 2 should be filed within 72 hours efter death with the Marylar near or Health and Mental Hygiene.

Int: If I lem 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified as 1 Yas 2 No Directo MARYLAND CHARLES WALDORF 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 11907 MONTGOMERY LANE 20602 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 14. Race - American Indian, Black, White, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decadent's Education (Spacify only highast grade completed) Elementery/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumema) GEORGE L. LARSEN STELLA C. WILLIAMS 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) JOSEPH F. FUESE/HUSBAND 11907 MONTGOMERY LANE, WALDORF, MARYLAND 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Method of Di 20c. Location - City or Town, Stata permit. Pages Department of Important: If it any injury or o 1 Burial Compation 3 | Ramoval from State TRINITY MEMORIAL GARDENS 10-03-2000 WALDORF, MARYLAND 5 Other (Specify) THE HUNTT FUNERAL HOME, INC. many P.O.BOX 156, WALDORF, MARYLAND 20604 RK G. BROHAWN M00053 mew 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final disaase or condition resulting in death) CONGESTIVE HEART Examiner CARDIOMYOPATHY Examiner ILATED attending physician end for use as the buriel-trensit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760, Physician/Medical that initiated avants rasulting in death) Last Dua to (or as a consaquance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the a 23b. Dld tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CEREBROVASCULAR ACCIDENT p 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of ceusa of death? is certificate has director, page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was casa rafarrad to medical axeminar? Be 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: AXXNursing Home 5 Assidence 6 Other (Specify) 2 1 Yas 2 No this funeral 27. Mennar of Death 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: After 1 Netural 5 Panding invastigation 1 ☐ Yas 2 ☐ No death. efter death.

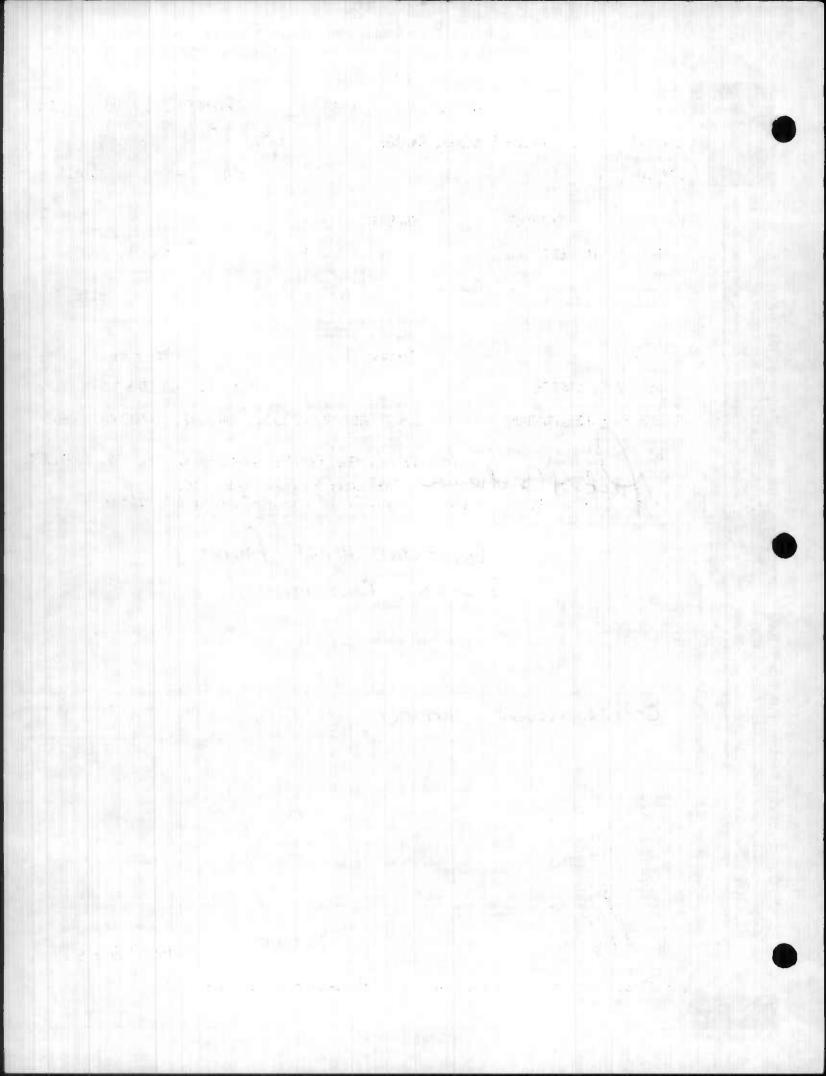
Director: A 2 Accident 6 Could not be datarmined 3 ☐ Suicide Location (Street and Number or Rural Routa Number, City or Town, Steta) 28e. Place of Injury - At home, farm, streat, fectory, office building, atc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b 4 ☐ Homicide 29a. Certifier 🙇 Certifying Physician: To tha best of my knowladge, death occurred at tha tima, data and place, and dua to the cause(s) end menner es stated. Medical Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and pleca, and due to the cause(s) and manner stated. 29b. Signatura 29c. Liceosa number 29d. Data signed (Month, Day, Year) 153885 MD SEPTEMBER 30, 2000 30. Nama and addrass of person who completed causa of death (Itam 23a) (Typa, Print)

VENKAT S. RAMANAN, MD, 6 POST OFFICE ROAD, WALDORF, MARYLAND 20602

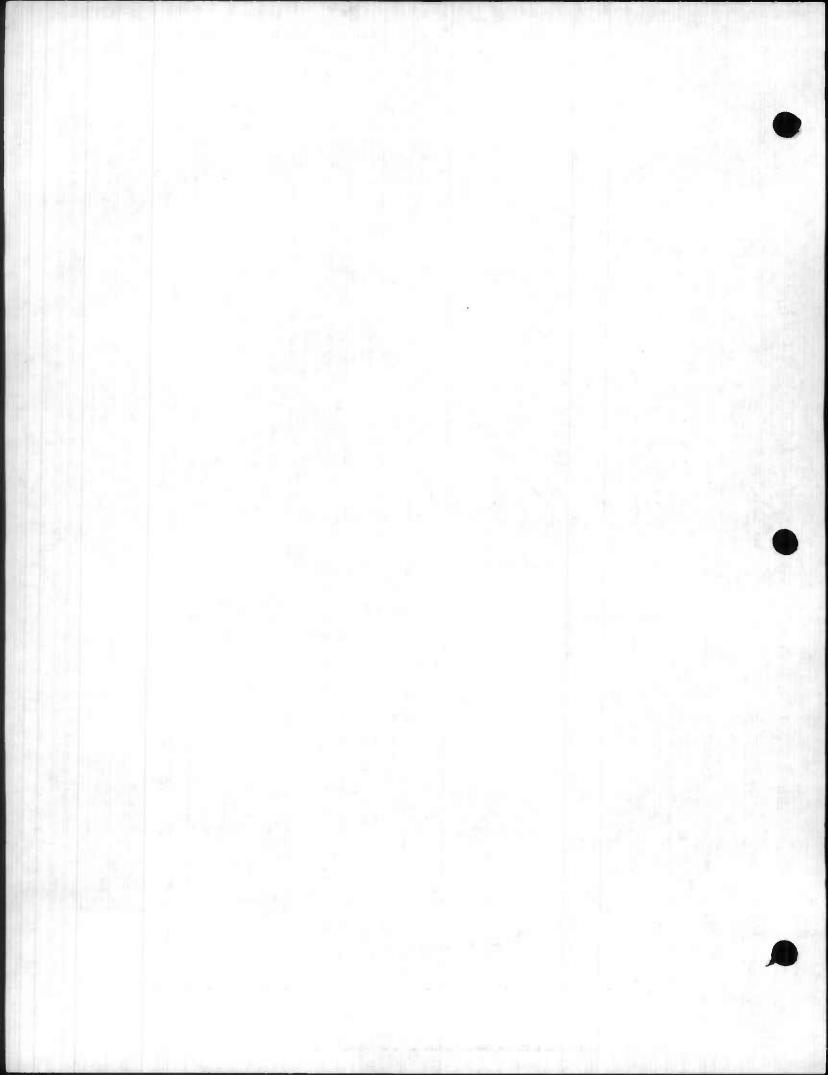
32. Ragistraf's Signatura

State Registrar 31. Data filad (Month, Day, Year)

OCT 0 2 2000



			Ce	ertificate o	t Death	P	eg. No.		
Physician	Decedent's Name (First, Middle, Last DANIEL ANT		RIS			2. Date of Dea Month SEPT	Day	Year OO	3. Time of Death 10:09 PM
/Medical Examiner	4a Facility Name (If not institution, give					or Location of Death	4c. County	of Death	
	CIVISTA MEDICAL CENT			T # 11 - 1 - 1 V		PLATA	CHAR		
uneral irector	213 30 1030	7. Age (In yrs. last birthday 50 Yrs.	Months Day		s. Date of Birth (Month, Day) AUG • 14		9. Birthpla Country VIRG	ice (State or Foreign y) INIA
3	Usual Rasidence of Decedant 10a. State 10b. County	11	Oc. City, Town or L	ocation				100	d. fnsida City Limits
be notified at Director	MARYLAND CHAR				BURY				1 Yas 2 No
23a or 28a-fa unt be notifies ral Directo	10e. Street and Number 4305 PIPER LAN	E		10f. Zip Cod	0658	1	Og. Citizen of W		y?
iner must iner must Funeral	11. Maritaf Status	12. Was Decedent Ev Armed Forces?	ar in U,S. 13.	Wes Decedent of	of Hispanic Origin?	(Specify Yes or No- arto Rican, etc.)		- American	
by by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1X Yes 2 No If Yes, Give U Year or Datas: 1		1 Yes 2 DX		arto riioari, oto.,	Specify:		
r, the Medical Completed	15. Decedent's Ed (Specify only highest grad	ucetion de completed)	16a. Deci (Giv. life.	edent's Usual Oce a kind of work do DO NOT use ret	cupation ne during most of v ired)	vorking	16b. Kind of Bu	siness/Indu	istry
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Be C	17. Father's Name (First, Middle, Last)					lame (First, Middla,			AMOSEMEN
To B	WILLIAM JO	SEPH FERF	RIS		SHI	RLEY COR	RD		
Pauma	19a. Informant's Name/Relationship (7 SHARON FERRIS-			ling Address (Str		Rural Routa Numba	r, City or Town,	State, Zip C	Pode)
mportant: If flam iny injury or othe ince.	20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licenters)) 1	RINITY	MEM • GA	RDENS 1 dress of Facility	0-5-00 V		F, MAF	
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esician edical aminer	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. ISCI		hea			est,		Approximate interval Between Onset end Death
ding physician and se as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	ue to (or as a conse						
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by the sached	Part ff. Other significant conditions co	entributing to death but	not resulting in the	underlying ceuse	given in Part I.		obacco use cor rea 2 No		the cause of death?
should be						24a. Was a		aval	re eutopsy findings llable prior to spletion of ceuse eath?
page 2						10Y	es 2 No	10	Yas 212 No
is certificate hadirector, page	25. Was case referred to medical examiner?					Death (Check only o	ne)		
	1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	BHT 3LI DOA		g Home 5 ☐ Resid	ence 6 Oth	er (Specity))
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To the Funeral Director: Attart completely filled in by the funeral Medical Certification:	3 ☐ Suicida 6 ☐ Could not be determined	28e. Place of Injury building, etc.	/ - At home, farm, s (Specify)	treet, fectory, offi	се	28f. Location (S City or Tou	itreet and Numb n, State)	er or Rural	Route Number,
pletely fille edical (vsician: To the best of diner: On the basis of each and manner state	xamination and/or i						
Toth	29b. Signeture and title of certifier		-	29c. Lic	anse number		29d. Data signad		lay, Year)
	your u.	Tagan	- 20		D-50883		9-30	-00	
	30. Name and address of person who of AHIA TAGOURI MD ST.I				25500 PT. I	OOKOUT RD.	LEONARDIO	MN, MD	20650
State	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	4. h	a Val				



Amended Item #20b, Per F.D., 09/28/2000, Carroll County, cew Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James otembre 25 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (ff not institution, give street and number) Examiner of the state of th 7. Age (In v/s. lest birthday) KIN If Under 1 Year Security Number 9. Birthplace (Stete or Foreign **Funeral** Days 1 MM 2□ F 73 MARYLAND Director 215-22-1146 Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show item 27 is marked other than "natural", or itema 23a or 28a-f shoother traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Funeral Director MD. CARROLL FINKSBURG 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 2405 SHAWNEE DR. 21048 USA. filed within 72 hours efter deeth 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Hace - American Indian, Black, White, etc. 11 Marital Status to Yes 2 □ No if Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1□ Yes 2XNo Specify: WHITE Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) 1 2 Collega (1-4or 5+) BOWLING CENTERS ACCOUNTANT 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fathar's Name (First, Middle, Last) permit. Peges 1 and 2 should be fill Department of Health and Mentel H Important: If Item 27 Is marked out any Injury or other traumatic even once. Pages 1 and 2 should be nent of Health end Mentel JAMES JOSEPH FOGARTY JR. MARY O. BRENNAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rurel Route Number, City or Town, Stete, Zip Code) MARY A. FOGARTY - WIFE 2405 SHAWNEE DR., FINKSBURG, MD. 21048 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 9/29/00 XXBurial 2 Cremation 3 Removal from State EVERGREEN MEM.GARDENS 10/29/00 FINKSBURG, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityFLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 20 days aspiration smounderg Examiner Dua to (or as a consequence ot): Physician/Medical Examiner normal airway Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Diseasa or injury that initiated events The lew requires that the death certificate be execu Box 68760. been signed by the ettending physician should be detached for use as the buria provascular accident that initiated events resulting in death) Last Due to (or as a consequance of): Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ersi Director: After this certificate hes filled in by the funeral director, page 2 1 Yes 2 K No 1 ☐ Yes 2 M No I or Attending Physician: after death. 25. Was casa rafarred to medical examiner? 26. Placa of Death (Check only one) Hospital: 1 Sc Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) Medical Certification: To 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accidant 3 Suicide 6 ☐ Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral Completaly filled 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dev. Year) 29c. License number 29b. Signature and title of certifier RES-000 September 26, 2000 Intern January MD, PhD WOLFE ST. 600 N. 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

Registrar SEP 2 8 2000

31. Date filed (Month, Dey, Yeer)

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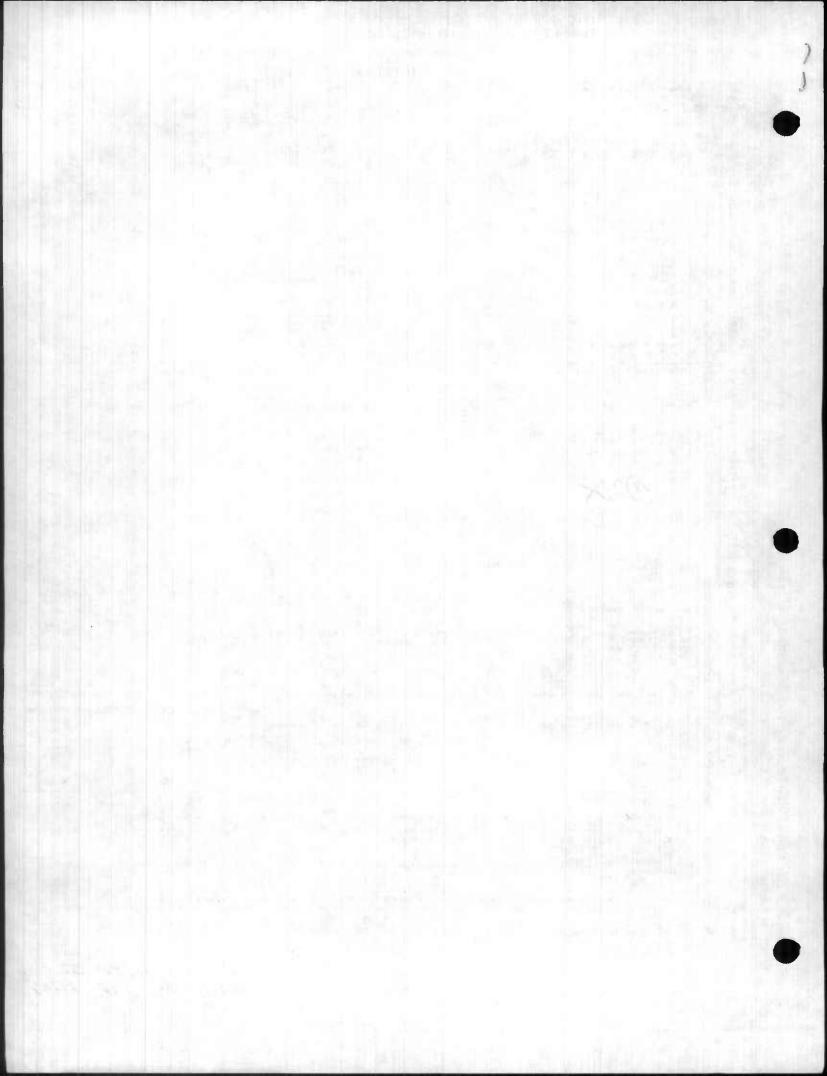
32. Registrar's Signature

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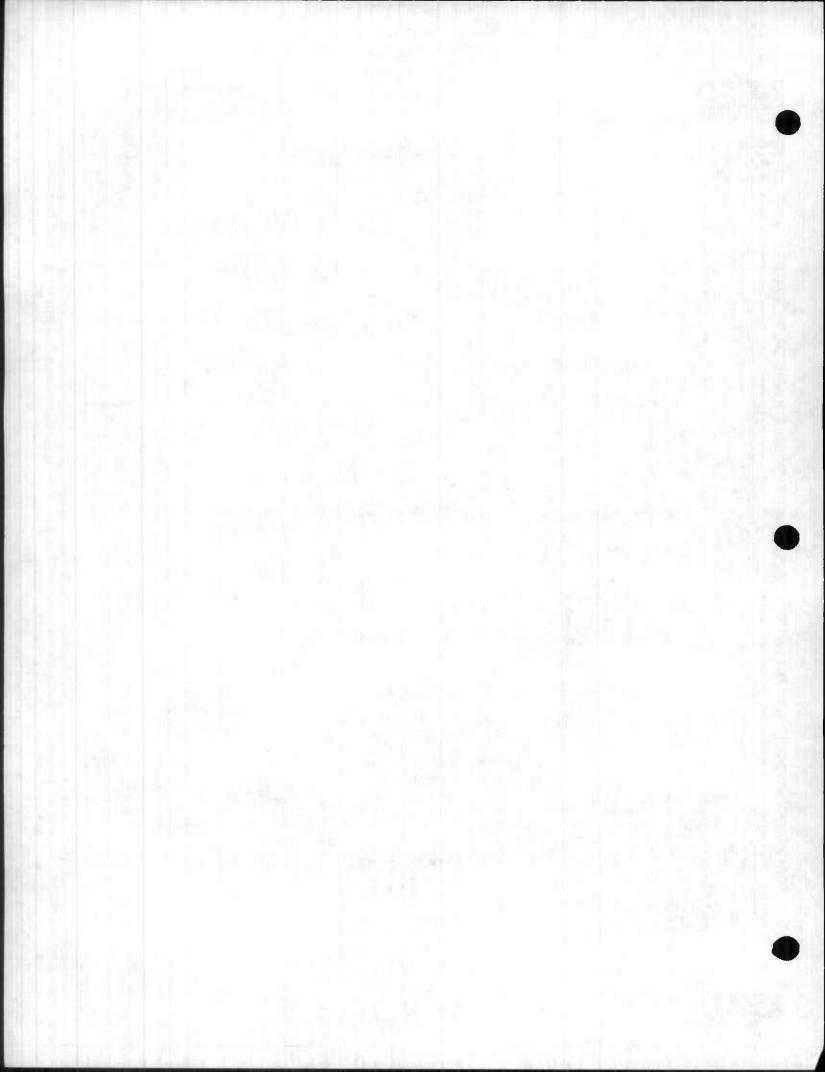
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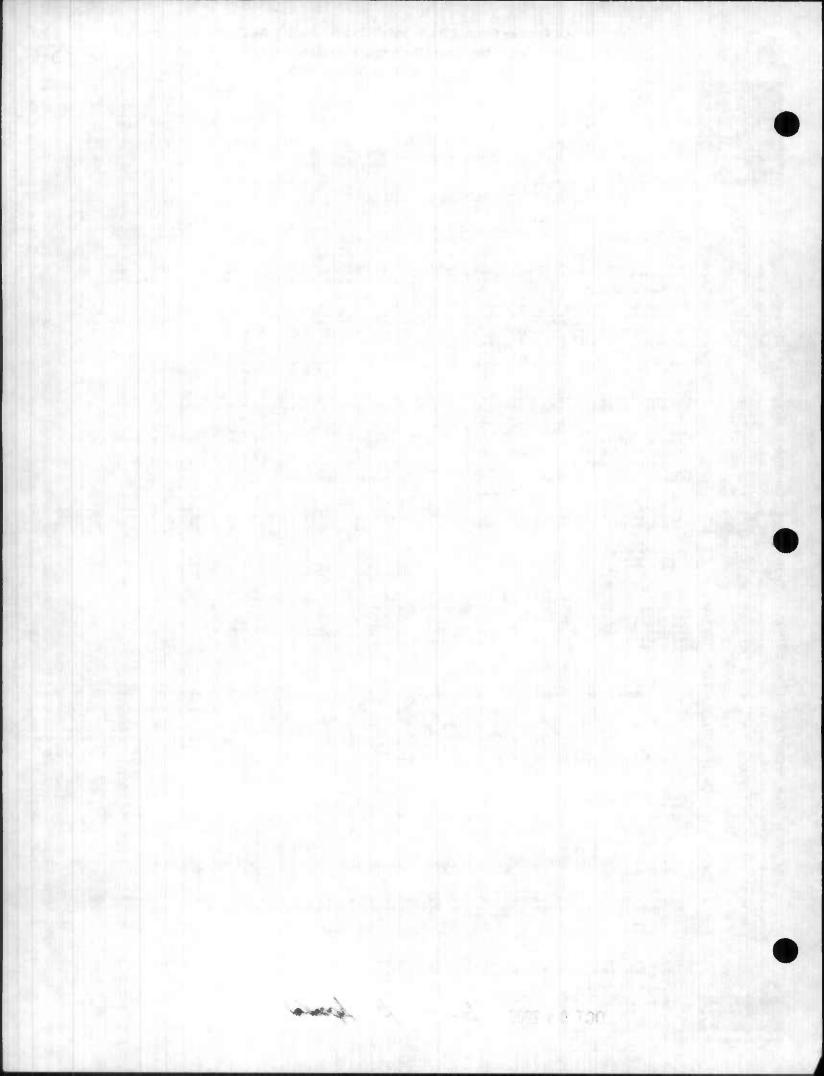


State of Maryland / D	epartment of Health and	Mental Hygiene	3224
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8	Physician /Medical		ELSIE		FISHE	R				Month SEPTEM	Day	Yaar	2:40 AN
	Examiner		la Facility Name (If not institution, gr					4t		or Location of Death	4c. County	of Death	
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	uneral irector			Sex 1□M 2\subseteq F	7. Age (In yrs. 99		Months f	Year Days	If Under 24 Hours	Ain. 8. Date of Birt (Month, Da Sept. 6	, Year) , 1901	9. Birthplac Country Mary	e (State or Foreign land
P		-	Usual Residence of Decedent		40- 6	T-11-	-1					404	Leader Ob Links
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th the	or 28	1	IOe. Street and Number				10f. Zip Co	ode			10g. Citizen of \	What Country	?
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5-0 72 h	area per		15. Decedent's E (Specify only highest g	ducation		16a. D	ecedent's Usual C live kind of work of te. DO NOT use	Occupa done di	tion unna most of	workina	16b. Kind of B	usiness/Indus	try
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d be	rice out		John W. Hill						Lott	ie Richar	dson		
Maryland d 2 should be file th and Mental Hy	THE P		19a. Informant's Name/Relationship	(Type, Print)		19b. N	lailing Address (S	Street a	nd Number o	r Rural Route Numbe	er, City or Town,	State, Zip Co	ode)
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Baltimore, Noemit. Pages 1 and Department of Health	Important: If frem 27 any injury or other tr phose.	_	20a. Method of Disposition 1 🖾 Burlal 2 □ Cramation 3 4 □ Donation 5 □ Other (Spec	☐Removal from S	20b. F	Placa of Doemetery,	isposition (Name crematory or othe apel Cen	of er place)	9/26/00	20c. Location		
Baltimol permit. Pages Department of	Important: any injury pncs.		21. Signal most Fund al Service Lice		last 20	2		Addres	s of Facility Ha	ertzler Fu		ome	
		+	23a. Part1. Enter the disease, or cor shock, or heert failure. List only	nplications that ca	used the baat	th. Do not						: Ac	oproximate terval Between
/Me Exa	edical edical iminer Examiner		Immediate Cause (Final disease or condition resulting in deeth)	a. <u>Co</u>	ODue to (or as a col	Heart nsequenca of):	F	aille	el.		3	years
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			Part II. Other significant conditions	contributing to de	ath but not res	sulting in th	ae underlying cau	se nive	n in Part I	23b. Dld	tobacco usa co	ntribute to th	s cause of death?
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To the Hospital or Attending within 24 hours effer death.	To the Funeral Director: After completely filled in by the funer Medical Certification:				sis of examina					laca, and due to the occurred at the time,			
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			30. Nama and address of person who					1 10	Enad-	rick MD 2	1701		
	State Registrar	-	Mary P. Howell 31. Date filed (Month, Day, Year) SEP 25	32. Re	I nomas gristrar's Signa	ature	son Dr.	nk		ick, MD 2	1701		



								Certificate of Death				Reg. No.				
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician MILDRED Μ. **GULLEDGE** SEPT. 19, 2000 12:00 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES CHEVERLY GEORGES GENERAL HOSPITAL PRINCE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10 M 200 239-40-2711 69 Director MARCH 17, 1931 NORTH CAROLINA **Usual Residence of Decedent** the Meryland permit. Peges 1 and 2 should be flied within 72 hours after deeth with the Merylen Department of Health end Mentel Hyglens. Important: if Itam 27 is marked other than "naturel", or itema 23s or 28s-f show eny Injury or other treumatic event, the Medical Examinar must be notified at 900s. 10b. County 10c. City, Town or Location 10e. State 10d. tnside City Limits XYYes 2□No Director MARYLAND PRINCE GEORGES CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 420 CEDARLEAF AVE. 20743 UNITED STATES Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 Yes ANO If Yes, Give Year or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: AFRO-AMERICAN à 3 Widowed XIX Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR BETHESDA NAVAL FOOD SERVICE 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Compl GOVERNMENT Elementary/Secondary (0-12) College (1-4or 5+) 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) e GEORGE SETTLE **THEDORE** SETTLE 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CHARLENE WILLIAMS / DAUGHTER 420 CEDARLEAF AVE., CAPITOL HEIGHTS, MD 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Murial 2 ☐ Cremation 3 ☐ Removel from Stete CEDAR HILL CEMETERY 09-25-2000 SUITLAND, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name end Address of Facility DUDLEY FUNERAL HOME
AVE., loc MT. RAINIER, MD 20712 3200 RHODE ISLAND Pert1. Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete triterval Between Onset end Death Physician tramediate Cause (Finel disease or condition resulting in death) /Medical RESPIRATORY FAILURE Examiner Due to (or es e consequence of) Examine ACUTE STROKE g physicien end es the buriel-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): HYPERTENSION 68760 Physician/Medical Due to (or es a consequence of): Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? CORONARY ARTERY DISEASE, PNEUMONIA, SEPSIS, 1 Yes 2 No 3 Probably 4 Unknown The law requires that Records. þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed RENAL INSUFFICIENCY, CONDUCTION SYSTEM DISEASE WITH PERMANENT PACEMAKER, ANEMIA 1 Yes XXXVo 1 ☐ Yes X ☒ No Vital Physician: 25. Wes case referred to medicat examiner? Be 26. Place of Deeth (Check only one) To. Hospitat: 1 ☑) inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ō this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After Division or Attending 5 Pending investigation Natural 2 Accident a efter death.
I Director: Aff 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, Ierm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or minin 24 hours of to the Funeral Di completely filled in XXX Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatury and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42982 SEPTEMBER 19, 2000 man 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1160 VARNUM STREET N.E., WASHINGTON, D.C.

State Registrar

22. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 2 6 2000

HERMAN GIST, M.D.



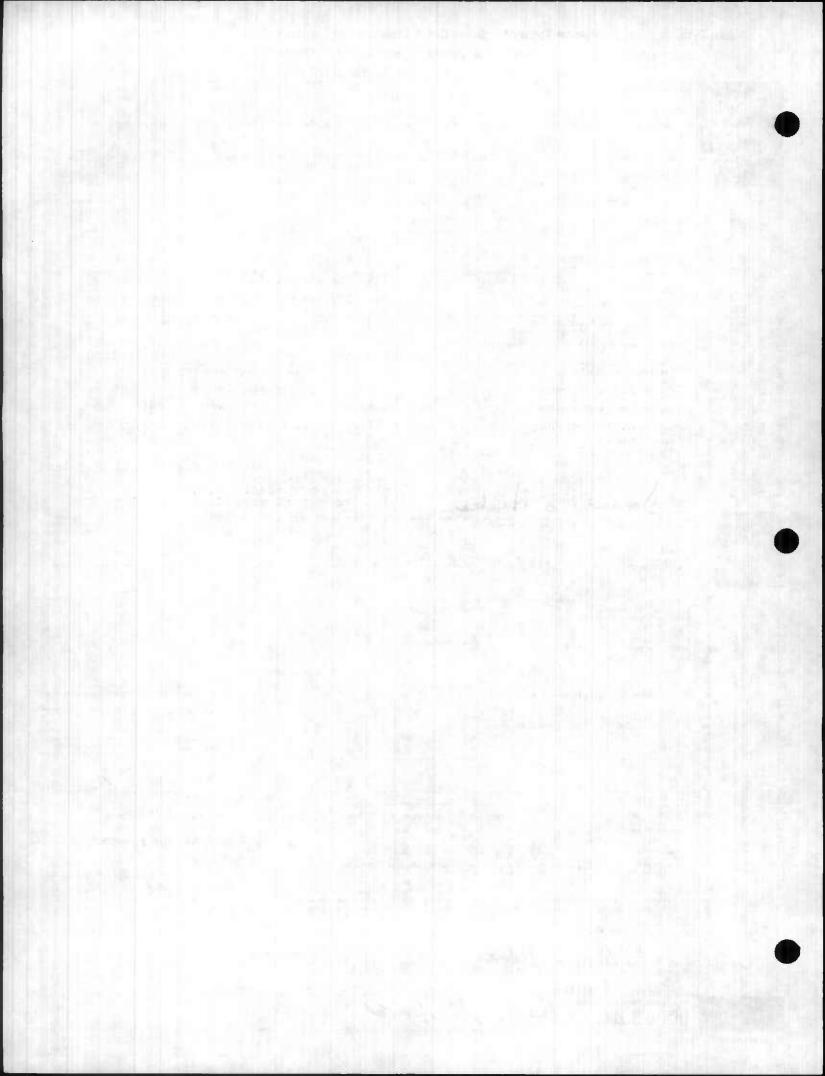
Bodie Goode Jr.

amend item	23a,27,28a,b,c,d,f,e per me G7 1. Decedent's Nema (First, Middle, Last)	88 10/30/00 yfCert	ificate of	Death	2. Date of Dee	eg. No.) 02	Tima of Death	
Physician				Month	Dey	Year	0.7541 - 1.49		
/Medical	Bobie Goode	Jr.	4b. City, Town, or Lo		ber 30		1405 pm		
Examiner	6608 Valley Park Road			leasant Prince George's					
Comment	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar				-		
Funeral Director	579-06-4365 Usual Residence of Decedent	Hours Min.	8. Date of Birth (Month, Dey, Year) 11-18-68 9. Birthplace (State or F Country) Roanoke, N						
nyland show	10a. State 10b. County 10c. City, Town or Location								
the Merylar 28a-f ehow could at	Maryland Prince Geo			Yes 2 No					
with the Me or 28a-fe be counted	10e. Street and Number 6608 Valley Park Roa	7.4.2		0g. Citizen of V					
a 23			207			United			
72 hours after death with the Meryland naturel; or items 23a or 28s-f show deal Examore must be notified at steed by Funeral Director	Armed F	orces? If 1	Yes, specify Cub	dispanto Origin? (Speen, Mexican, Puerto Specify:	Rican, etc.)		e - Amaricen froncisk, White, etc.		
ed within 72 hours ygiena. her than "naturel", ft, the Wester Exa Completed by	15. Decedent'a Education (Specify only highest grade completed	16e. Decede	ent's Usuel Occup ind of work done	petion during most of worki	ing	16b. Kind of Bu	usiness/Industry	1200	
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Saby W	Bobie Goode, Sr.				n Hardy				
d 2 should be th and Mental 7 is marked o treumatic eve	19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling	Address (Street	end Number or Rura	I Route Number	. City or Town.	Stete. Zip Code	,)	
2 4 4 5	Lachele Bethea (Wif	5620	Cypres	s Creek	Drive,	Apt.	203		
一工事者	20e. Method of Disposition		SVIIIE ition (Neme of etory or other ple	MD 20	Date	20c. Location -	City or Town, S	teta	
	Harmon Buriel 2 ☐ Cremetion 3 ☐ Removal from 4 ☐ Donetion 5 ☐ Other (Specify)	State			16/00	T 3 .			
permit. Peges Department of Important: If is eny injury or pnce.	21. Signeture of Funerel Septimi Licensee	22.	Nama end Addre	emorial Pk.10/6/00 Landover, MD.					
P P P P P P P P P P P P P P P P P P P	Qua SV	Fo	ope Fun orestvi	eral Hon	nes, 55	38 Mai	rlboro	Pk.	
	23a. Pert1. Enter the discussed complications that shock, or heart fail in list only one ceuse on	ceused the death. Do not enter	the mode of dyi	ng, such as cardiec o	or respiratory arr	est,		oximete vel Between	
Physician					Onse	et and Daeth			
/Medical Examiner	Immediate Cause (Finel disaasa or condition CONT	ACT GUNSHOT WOUND	OF HEAD						
ALC: NO.	resulting in death) a.	Due to (or es e consequ	ence of):						
executed in and inal-transit	b								
physician and sthe bunal-transit	Sequentially list conditions, if any, leeding to Immediate	Due to (or es e consequ	ence of):						
bunia Ba	Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events								
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The law ate has be page 2 sl					10/Y	es 2 No	15 X00		
certificate rector, pag	25. Wes casa referred to medice!			26. Place of Deetl	/		. Andre	20110	
	exeminer? Hospitel:	Inpatient 2 ER/Outpetient	3 DOA OH				er (Specify) =	t scone	
Br fee Co	27. Menner of Deeth 1 ☐ Neturel 5 ☐ Pending (Mo	28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury P 2:00 M			Home 5□ Residence 6 Mother (Specify) at scer 28d. Describe how injury occurred subject shot so			shot self	
Part P	4 Homicide build	building, etc. (Specify)				28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6608 Valley Park Rd., Seat Pleasant, Md.			
To the Hospital within 24 hours To the Funeral completely filled	29e. Certifier (Check only one) 1 Certifying Physician: To the to the control one)							ause(s)	
Nithin Nomple	29b. Signature and title of certifier		29c. Licanse number			29d. Date signed (Month, Dey			
->-0	111111	· d - a	0.C	.M.E.	October 01, 2000			00	
	30. Neme and address of person who complated cau								
	THEOROREM, Ker	111 Pe	enn Stre	et, Baltin	nore, Ma	ryland	21201		
State	31. Date filed (Month, Dey, Year) 32	Registrar's Signeture							
Registrar	OCT 0 4 2000 5	ever 4	1000						

State of Maryland / Department of Health and Mental Hygiene 11 32253

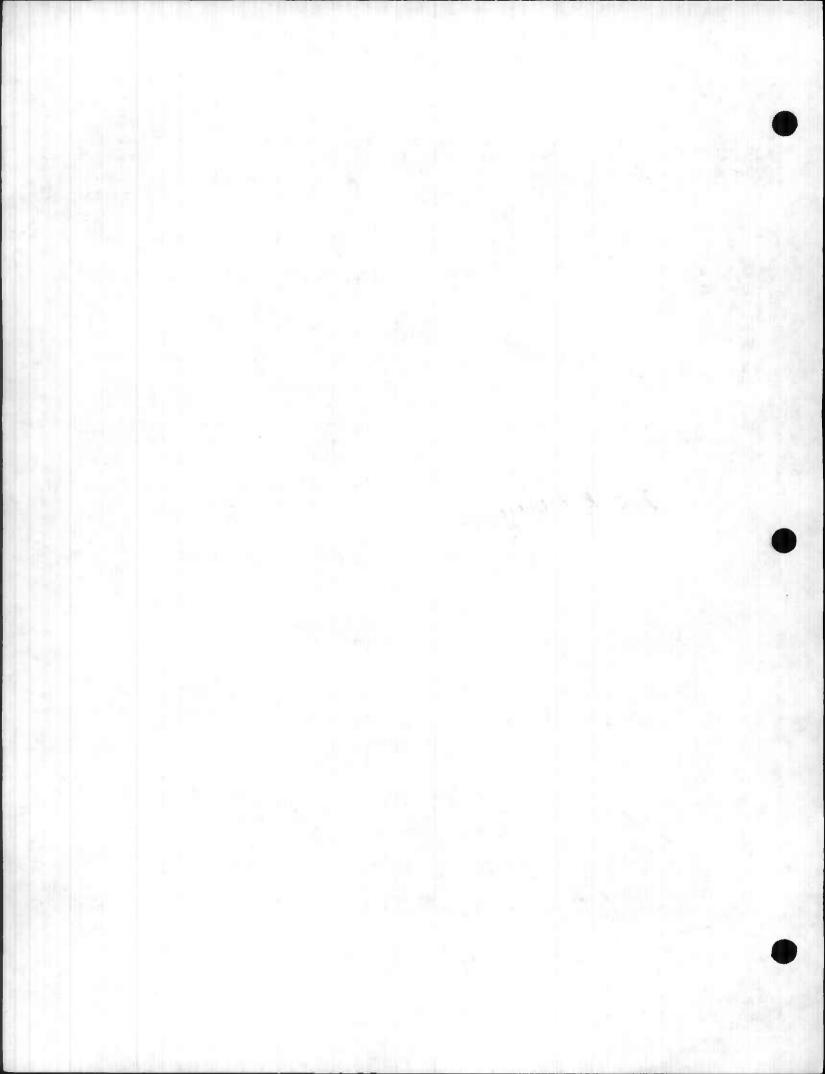
				Cei	rtitica	te of I	Death			Reg. No.	0	16600
Dhuaisian	1. Decedent's Neme (First, Midd	fle, Last)							2. Dete of De		Veer	3. Time of Deeth
Physician /Medical	Gary Duane Gibson SEPTEMBER 28,2000											01:03 A.M.
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, o											102000 11011
	PULASKI HIGHWAY AT BELVEDERE ROAD PERRYVI								LE	CECIL		
uneral	5. Social Security Number	ocial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24					24 Hrs.		te of Birth 9. B		place (State or Foreign	
ctor	213-82-0417	15XM 2□ F	25	Yrs.	Months	Deys	Hours	Min.	MAY 13		Cour	ntry) Land
	Usuel Residence of Decedent									liury	J.GIIG	
	10a. State 10b. Count	У	10c. C	City, Town or Lo	cation						1	Od. Inside City Limits
P	Maryland Ceci:	1	E	lkton								1 ☐ Yes 2 📉 No
9	10e. Street and Number				10f. Z	ip Code				10g. Citizen of	What Cour	ntry?
Ö		3										
Funeral Director	239 Hilltop Ro		cedent Ever in	J,S. 13. Was Decedent of Hispanic Origin? (Specify Yo					noity Vac or N	United States ify Yes or No- 14. Race - American Indie		
5	11. Marital Status	Armed I	Forces?	If Yes, specify Cuban, Mexican, Puerto					Rican, etc.)	Ble	ck, White,	
Dy	1 Never Merried 2 Me 3 Widowed 4 Divorce	. If Yes, C			1 ☐ Yes	2 No	Specify:		Specify: Whit			ite
D			Dates:	16a Dacadonia Haval Casumatica						100 100 100		
ete		nt's Education est grade completed	d)	16a. Dece	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of B	usiness/In	dustry
Completed	Elementery/Secondary (0-12)	College	(1-4or 5+)									
3	12			Truck Driver						Stone		ing
0	17. Father's Name (First, Middle			18. Mother's Na					e (First, Middle	, <i>Maid</i> en S <i>um</i> ar	ne)	
0	Duane Allen G		Debra Ann Sp					Sprout				
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,								, State, Zip	Code)		
	Duane A. Gibse	on/Father		239 1	Hillt	top R	oad,	Elkt	on, Ma	ryland 2	1921	
	20a. Method of Disposition		20b.	Place of Dispo			al.		Date	20c. Location	- City or To	own, State
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or farms 23a or 28e-f ahow eny injury or other traumatic event, the Mental Examiner mant be notified an once. To Be Completed by Funeral Director	1 Nonation 5 Other (n State Ch	cemetery, cres	1.1 M	letho	dist	1	0 /0 /00	C1		
	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility									Hill,	Maryl.and	
	21. Signature of Furieral Service	Licensee	-						als, P.	Α.		
D = 0 d	Donned	18-H	uko							ton, Mar	yl.and	21921
	23a. Part1. Enter the disease, of shock, or heart tailure. Lis	r complications that	caused the de	ath. Do not ent	er the mo	ode of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between
	Onset and Death											
	Immediate Cause (Final	N	1.11-11	5 True								
	Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Oue to (or as a consequence ot):											
er			009 10	(or as a consec	finetice of	.,.					1	
Ē		b		,								
edicai Examiner	Sequentially list conditions, Due to (or as a consequence ot): if any, leading to immediate											
100	cause. Enter Underlying Cause (Disease or injury Cause (Disease or inju											
ğ	that initiated events resulting in deeth) Lest Due to (or as a consequenca ot):											
3		d								Maria		
an L											1	
/sic	Part II. Other significant conditi	ons contributing to	death but not re	esulting in the u	nderlying	cause giv	en in Part I		23b. Did	tobacco use co	ontribute t	o the cause of death?
Physician									10	Yes all No	3 □ Pro	bebly 4 Unknown
DÀ											1	
										en autopsy ormed?	24b. W	ere autopsy tindings valiable prior to
Completed									ban		CO	ompletion of cause death?
The same									, Au	Van DDM		
						. 67	13			Yes 2□No	1	X Yes 2□ No
	25. Was case reterred to medical examiner?	Hospital:				04		ot Deatl	n (Check only	one)		
2	XIX Yes 2□ No	11		☐ ER/Outpetier			4 LJ NU		me 5 Res	4.6		b) SCENE
	27. Manner of Death 1 □Natural 5 □ Pendi		e ot Injury onth, Day Year)	28b. Time of Injury		28c. Injur	y at k?			now injury occu		for where la
Certification:	2/2 Accident invest	igation 9-2	28-00	0050	AM	10	Yes 2	No	- EUITS/	with hit	9100	io ochrece
2	3 Suicide 6 Could 4 Homicide determ	nined 200. Plac	ca of Injury - At	home, tarm, str	eet, tacto	ory, offica			28t. Location	(Street and Num	ber or Run	al Route Number,
10	4 CT HOINIGIO	BUII	ding, etc. (Spec	5trect					CPC:1	Co. Ad	a ski	Highway
		ng Physician: To th	ne best of my kr	nowledge, death						cause(s) and m		
edical		Examiner: On the										
Me	29b. Signature and title of certifier 29c. License number							-		29d. Date signe	ed (Month.	Day, Year)
	A)	10	,							SEPTEMBE		
	Clean	m deh	ng.			0.0	•11•10•			DE TEMPE	107	, 2000
	30. Name and address of person	who completed car	use of death (Ite	em 23a) (Type,	Print)							
	Dennis Chu	teno	111 F	enn Str	reet.	Bal	timor	e, M	aryland	1 21201		
	21 Date filed (Month Day Year) 22 Pagistrade Éigneture											
State	31. Date filed (Month, Dey, Year	32.	Registrar's Sign	nature	Kel							

Registrar DHMH 16 Rev 6/95



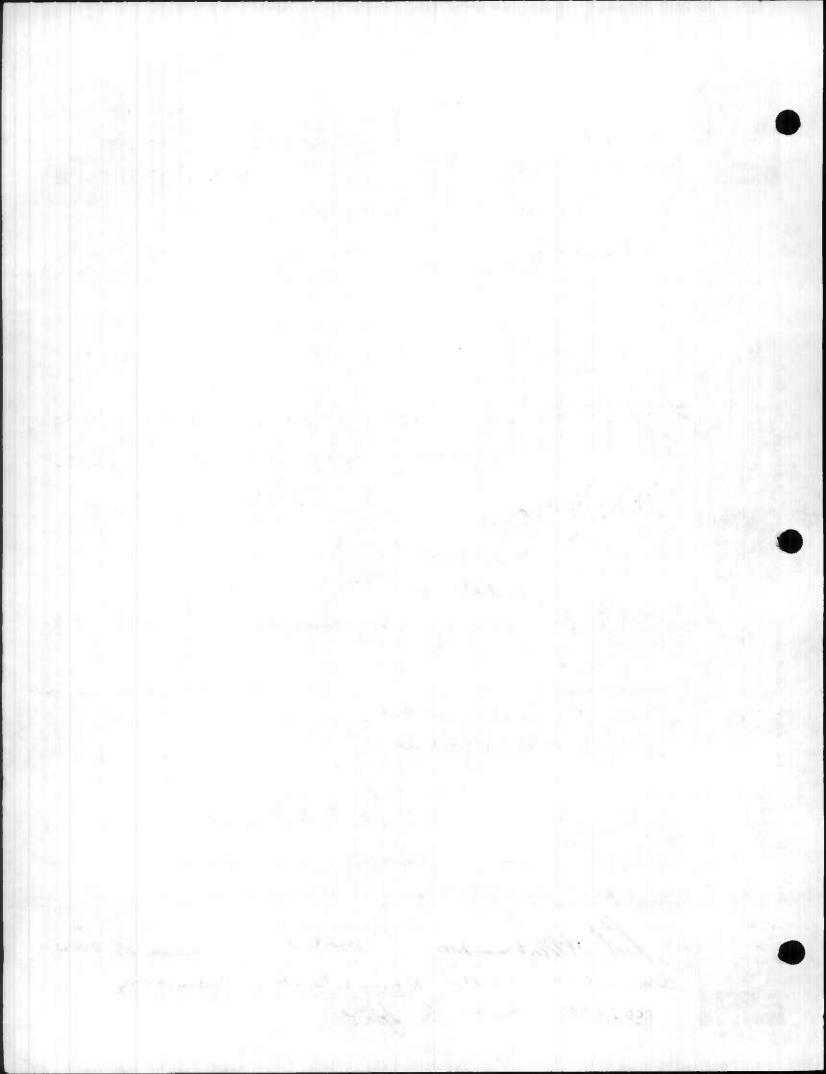
State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Workar 11)	Reg. No.	0 3	2254					
	Physician	Decedent's Nama (First, Middla, Last)	2. Date of Do Month		Year	3. Tima of Death					
	/Medical	EVELYN M GROTON	SEPT			5:35 AM					
	Examiner	4a Facility Nama (If not institution, give street and number) 4b. City, Town, or									
		SALISBURY Center; Genesis ElderCare Salisbur		Wicom		(0)					
	Funeral Director	5. Social Security Number 222-05-5508 6. Sex 1 M 27 F 80 7. Aga (In yrs. last birthday) Nonths Days Hours Min	. (Month, D	24,1920		aca (Steta or Foraign ry) .aware					
da da	8 11	10a. Stata 10b. County 10c. City, Town or Location			10	d. Insida City Limits					
2	i o	Maryland Wicomico Salisbury				1 Yes 2□No					
÷	or 28s-f s	10e. Street and Number 10f. Zip Code		10g. Citizen of V	Vhat Count	ry?					
3	, a G	200 Civic Ave. 21804		USA							
9	r tems 23s	11. Merital Status 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pua	Specify Yas or N	o- 14. Raci	e - America ck, White, a						
TON Aaryland 21215-0020	Transparence control of the control	1	no rican, aic.,	Specify							
5-0-2	natural', adical Emilente	15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of work life. DO NOT use ratired)	orking	16b. Kind of Businass/Industry		ustry					
21	tal Hygiena. Jother than "nature wort, on Medical Be Completed	Elementary/Secondary (0-12) College (1-4or 5+) lifa. DO NOT usa ratired)		- T							
7 3	Hygie Rher B	11 - Nurse	Health Care								
SUE SUE	and Mental Hygiena. To Be Comp		Joseph	na (First, Middla, Meiden Sumema)							
	and Mental			hor City or Town	State Zin	Code					
GROLON re, Mary			Rural Routa Number, City or Town, Stata, Zip Coda) Salisbury, MD 21801			COUG)					
6, 6	- 7 5 5	20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place)	Dala	20c. Location -		wn, Stata					
0 4	int: #	1 Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Springhill Memory Cardens	9/26/00	Hebror							
Baltimo	Department Important: Important: Pany Injury o	21. Signature of Funaral Service Lice 22. Name and Address of Facility Holloway Funeral									
		501 Snow Hill Rd.			2180	Approximeta					
-	huninian	23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardie shock, or heart failure. List only one cause in each line.				Inlarval Batwaan Onsat and Daath					
	hysician /Medical	Immediata Cause (Final disease or condition Perup Herry US culture	Deso	Ma	6	sens					
E	xaminer	disease or condition resulting in death) Due to (or as a consequence of):	1200	10 pc		J. 1, 1					
	ě				1						
of the Control	physician end s the burial-transit	Sequentially list conditions, Due to (or es a consequence of):									
o,	urial-	Sequentially list conditions, if any, laading to immadiate cause. Enter Undertying Cause (Disease or injury c.									
68760,	physicials the burners and call all	Cause (Disease or injury c									
X Q	ing p as a s										
Box	d by the attending gelached for use as										
0 8	the short	Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I.	23b. Did tobacco use contribute to the cause of de								
Division of Vital Records, P.O	ed by the attending detached for use		1	Yes 2□ No	3 Prob	ably 4 Unknow					
sp.	should be det		24a. We	s en autopsy	24b. Wa	ra autopsy findings					
00	shou		per	formed?	con	nilabla prior to nplation of causa death?					
B S	sate has been si page 2 should		10	Yas 22 No							
la l	certificate irector, pag			-		Yas 22 No					
> 5	is certificate had director, page		eeth (Check only	ona) sidance 6 □Oth	os (Canaih	6)					
O A	rthis aral di	27. Manger of Death 28a. Dete of Injury 28b. Tima of 28c. Injury at	1	how injury occur		7					
O	After funding	1 Neturel 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M I Yas 2 No									
/iSi	rs after death. Is Director: After to led in by the funera Certification:	3 Suicide 6 Could not be determined 28a. Place of Injury - At homa, farm, straat, fectory, office	28f. Location	(Street and Numb	per or Rura.	l Routa Number,					
io s	d in	4 Homicide building, atc. (Specify)	City of Te	own, Steta)							
Division of Vital Records, P.O. Box 68760,	within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	29a. Cartifier (Check only Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, daath occurred at the tima, data and place, and dua to the causa(s) end menner es stated. (Check only Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, daath occurred at the tima, data and place, and dua to the cause(s)									
2	thin 2 mple	one) and mannar stated. 29b. Signatura and title of cartifiar 29c. Licansa number		29d. Data signe	d (Month	Dav. Year)					
A P	3 F 8	290. Signatura and timbol comman	13	9/		/					
	1.0	1 0000		1/2	-0/	w					
	ym	30. Nama and addrass of person who completed cause of daath (Itam 23a) (Type, Print)									
		31. Data filed (Month, Day, Xear) 32 Registrar's Signatura	., SALISE	BURY, MD	2180)4					
	State Registrar	31. Data filed (Month, Day, Year) SEP 2 2000 32 Registrar's Signatura Sep 2 6 2000									
	riegistial										



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Dacedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** SARAH PAULINE HANSARD SEPT. 24,2000 2:25 PM /Medical 4a. Facility Name (If not institution, give straat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY If Undar 1 Year | If Undar 24 Hrs. | 8. Data of Birth 5. Social Sacurity Number 7. Age (In yrs. last birthday) 6. Sex Birthpiaca (State or Foreign Country) **Funeral** 229-09-8049 Months 1 M 20 F 83 Yrs. Director SEPT.6,1917 VIRGINIA Usual Residence of Decedent the Meryland 10a. Stata 10b. County "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. inside City Limits VA. SHENANDOAH WOODSTOCK Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 935 - OX ROAD 22664 USA death Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒No !f Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Year or Dates: I Hygiene. other than "natura rent, the Madical E Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) KEY PUNCHER NOT AVAILABLE Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Surnama) . Pages 1 and 2 should be filment of Health and Mental Hant: If item 27 is marked offury or other traumetic ever RUFUS A. WILKINS TENIE E. HELSLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALFRED L. HANSARD-SON 2128- HERBERT AVE., WESTMINSTER, MD. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Ramovai from State permit. Page Depertment of Important: If any injury or once. NATIONAL MEM. PARK 9/27/2000-FALLS CHURCH, VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sa 22. Name and Address of Facility Hysong Company, Inc. 6510 - 16th Street, N. W., Wash. DC Approximate Interval Between Onsel and Death 23a. Part1. Enter the disas shock, or heart failure **Physician** Immediate Cause (Final diseasa or condition resulting in death) /Medical 12URC **Examiner** Dua to (or as a consaquance of) betes nellities The lew requires that the death certificate be executed Due to (or as a consequence of): Sequentially ilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lasl burial-tran Box 68760, arken clisier Due to (or as a consequence of) Physician/Medical ettending physical for use as the t P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 No scular accedit Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peen certificate has 1 Tas 2 X No 1 ☐ Yas 2 ☐ No Division of Vital Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No spital or Attending Physhours after death.
neral Director: After this y filled in by the funeral di After this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and pre-of gertifier 29c. Licanse number 29d. Data signed (Month, Day, Year) D54612 September 25, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMUEL G. MALLER M.D. National Lutterantione . Registrar's Signatura 31. Date filad (Month, Day, Year) SEP 2 6 2000 Registrar



Physician Sept. 2000 Ethel Lee Hairston /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's Hours Min. 8. Date of Birth (Month, Day, Year) Dec. 28, 1 If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Days Months 1□ M 2√ F 88 -90-Yrs. 1909 North Carolina 579-16-6164 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at Directo Maryland | Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zlp Code 20772 17136 Fairway View Lane United States Funeral 14. Race - Americen Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 11. Marital Status hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 21215-0036 1 Yes 2 No Specify: Specify: Negro-Indian by 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) llth Cafeteria Worker Private Maryland 17. Fether's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Pages 1 and 2 should be filment of Health end Mente? Hant: If Item 27 le marked oft Unknown linknown 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles H. Hairston - Son 11 Seaton Place, N.W. Wash., D.C. Baltimore, 20b. Piace of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If eny Injury or once. ò Lee's Crematory 9/30/2000 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lighnsee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, short or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in Guath) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): ettending physician for use as the burie Physician/Medical Due to (or es e consequence of): US0 08 L ed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed by Hairston, Ethel À 24e. Wes en autopsy performed? Be Completed this certificate has 1 Yes 2 No 25. Was cese referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 PH/Outpatient 3 DOA 1 Yes 2 Do Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of-Deeth 28c. Injury at Work? or Attending 5 Pending investigation 1 AMatural

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

20001

20019

24b. Were autopsy tindings available prior to completion of ceuse of death?

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Clinton, Md

29d. Date eigned (Month, Day, Year)

Approximate Interval Between Onset and Death

1 Yes 2 No

23:45

2. Date of Death

Month

To the Hospital within 24 hours To the Funeral State Registrar

efter death. Director: Af

edical

T

(P)

09/25/2000

31. Date filed (Month, Day, Year) SEP 2 9 2000

29b. Signeture end title of certifier

2 Accident

4 Homicide

3 Suicide

29a. Certifier

6 Could not be

1. Decedent's Name (First, Middle, Last)

ESSAM TEllawi 7700 32. Registrar's Signature

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

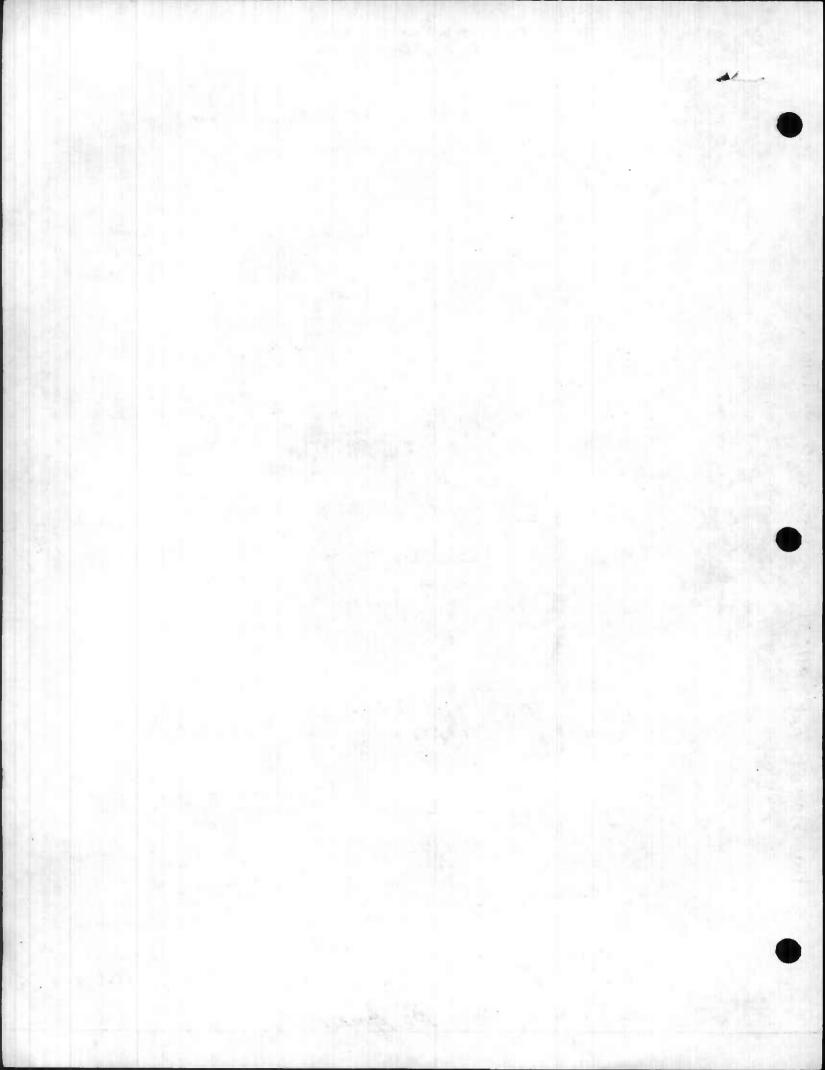
ORIGINAL

1 Yes 2 No

1 Contring Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

Old Branch Ave.

29c. License number



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** Alease Holbrooks 17, 2000 September 11:20 A.M. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Community Hospital Cheverly Prince George If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Steta or Foraign Country) **Funeral** 1 M 2 F Yrs. Director 577-22-3174 May 5,1909 Virginia Usuai Rasidence of Decedant the Maryland 10a, Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Nems 23a or 28a-f ehor Md Prince George Forestville Yas 2□No Director 10f. Zip Coda 20747 10e. Street and Number 10g. Citizen of What Country? 1902 County Road United States of America Funeral 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedant Evar in U,S Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 72 hours after 1 Nevar Married 2 Married 1 Yas 2 No If Yes, Give Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry filed within Elamantary/Secondary (0-12) Collega (1-4or 5+) Waitress Private 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Pages 1 and 2 should be nent of Health and Mental is marked Thomas Lewis Sallie Cousins 0 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1902 County Road T2 Forestville Maryland 20747 Alease Terry permit. Pages 1 and 2 Department of Health a important: If item 27 is any injury or other tre Daughter 20b. Placa of Disposition (Nama of 20a. Mathod of Disposition 20c. Location - City or Town, Stata camatary, crematory or othar placa) 1 Burial 2 Cramation 3 Ramoval from Stata Chesapeake Crematory 9-22-2000 Beltsville, Maryland 4 Donation 5 Other (Specify) 22. Nama and Addrass of Facility Robert O. Freeman Funeral Services Freeman da M. 1353 H Street N.E. Washington D.C. 20002 blications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enfer tha disaasa, or com shock, or heart failura. List only Approximata Intarval Batween Onset end Death **Physician** Cantel 0 10/0 /Medical Immediata Causa (Final disaasa or condition rasulting in death) **Examiner** Examiner Sequantially list conditions, if any, leeding to immadiata causa. Entar Underlying Cause (Disaase or injury that initiated evants resulting in daath) Last Dua to (or as a consequence of): physician s the burial P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in tha undarlying causa givan in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ Records. 8.8 24b. Wara autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy 1 Yas 2 PINO 1 ☐ Yas 2 ☐ No of Vital 25. Was case referred to medical Be 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) TO Yes 20 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 4 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division Attending 1 DMatural 5 Pending after death. 1 Yas 2 No investigation 2 ☐ Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide ò 24 hours a Furneral Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and dua to the causa(s) and mennar as stated.

I Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier edical

State Registrar

SEP 2 5 2000

29b. Signature and title of bertillies

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and mannar statad.

30. Name and address of person who completed causa of death (Itam 23a) (Type, Pr

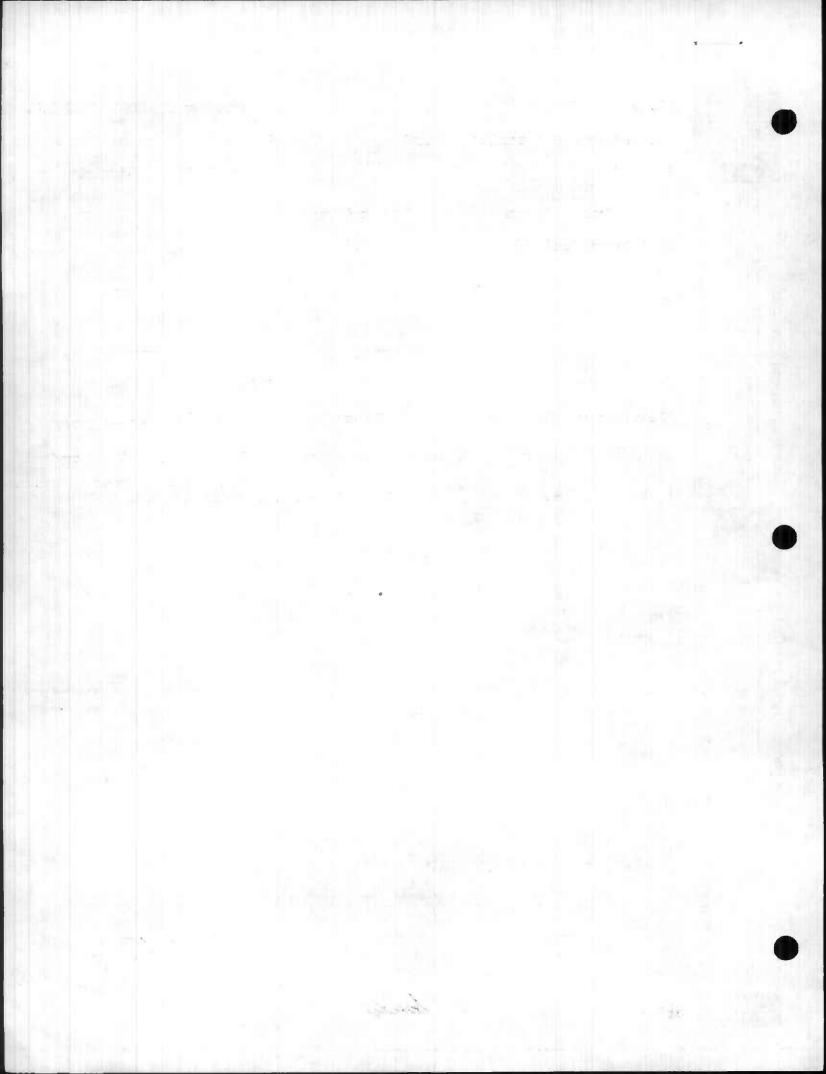
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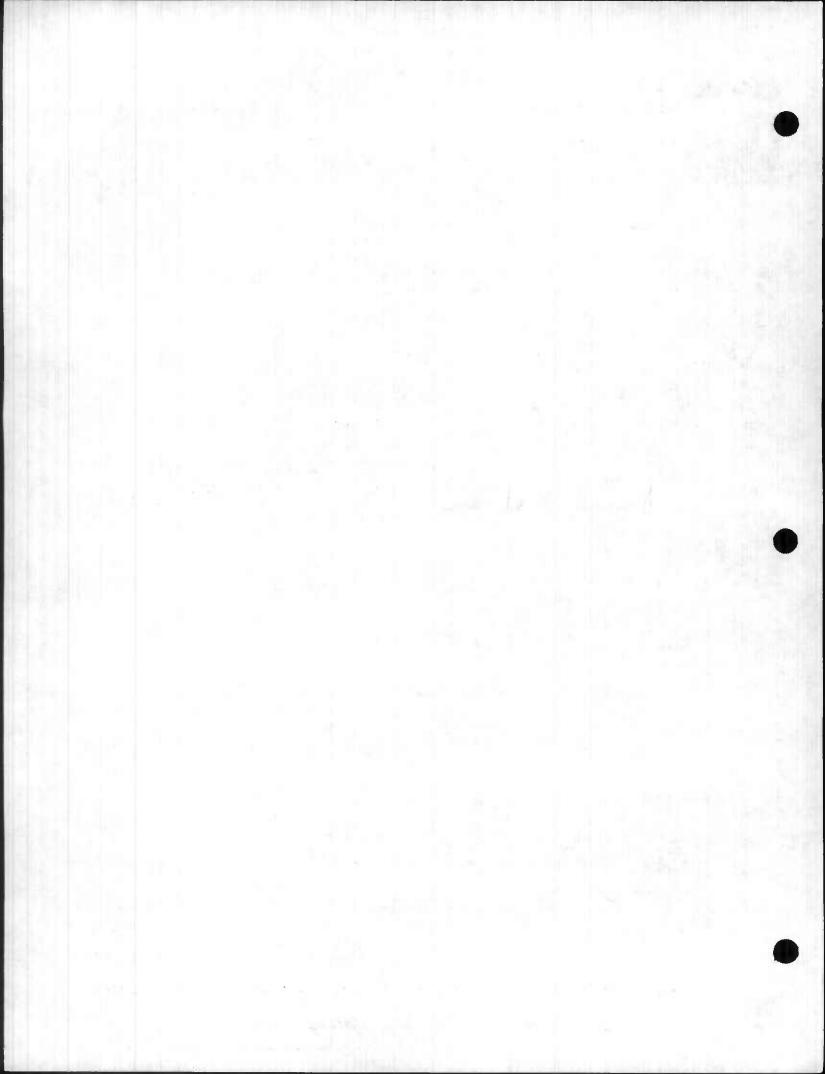
29d. Date signed (Month, Day, Year)



State of Maryland / Department of H

Health and Mental Hy	giene 🕦 🕦	3	2	2	5	8	
Death	Reg. No.	0	£	-	U	0	

				Certi	ificate of	Death	R	eg. No.		
		1. Decedent's Name (First, Middle, La	sf)	317.5			2. Date of Dear			3. Time of Death
	Physician	Julia Ersie Hend	erson				Month Day September 25		Year	1405 P
	/Medical	4a Facility Name (If not institution, giv				4b. City, Town, or	-	4c. County of		1403 P
MAN.	Examiner	Union Hospital				Elkton		Cecil		
		5. Social Security Number 6. S	Sex 7. Age (In yrs.	last hirthday)	If Under 1 Year		8. Date of Birth			ace (State or Foreign
	Funeral Director	199-05-8009	199-05-8009 1 M 2 XF 93 Yrs. Months Days Hours Min. (Month, I OCT 14							ace (State or Foreign ry) inia
2	1.	10a. State 10b. County		10	d. Inside City Limits					
Many	t show	Manual		ity, Town or Loca						1 ☐ Yes 2 💢 No
2	be notified Director	Maryland Cecil 10e. Street and Number	R1	sing Sur	10f. Zip Code		1	0g. Citizen of W	hat Count	rv?
dh with		1881 Telegraph R	oad		21911			United		
de	iner.must iner.must Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J,S. 13. Wa	as Decedent of res, specify Cut	Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No- to Rican, etc.)	No- 14. Race - American In Black, White, etc.		
Maryland 21215-0020	Exam by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Yes 2∭ No			Specify: White		
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121 Atthin	Mp Mp	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retire	ed)		T O	TY = ==	
d 2		17. Father's Name (First, Middle, Last)	Homem	aker	18. Mother's Na	me (First, Middle, I	In Own		е
8 8	Mental H riked off file ever To Be									
7	d Men marks marks	Robert Ingram 19a. Informant's Name/Relationship (Type Brint	10h Mailing	Address (Street	Jane Dane Dane Dane Dane Dane Dane Dane D		City or Town	State Zin	Code)
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	Manth Mar 17	20a. Method of Disposition		Place of Disposit		i Road, Ki		20c. Location - (
Baltimore,	int: If its	1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, crema	tory or other pla		9/29/00			
Salti	Appart mports my inju	21. Signature of Funeral Service Licer		22. N	Name and Addr					
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		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	th. Do not enter	the mode of dy	ing, such as cardia	c or respiratory arr	esi,		Approximate tnterval Between
	nysician Medical	tmmediate Cause (Final	0.10							Onset and Death
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N) 5	physician and s the burial-transit	Sequentially list conditions.	b. Due to (or as a conseque	ence of):	00	.,,			h - 7 to -
0,	ian ar infal-t	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events							i	
68760,	physicials the burners the burners and call call call call call call call cal	that initiated events resulting in death) Last	C. Due to (or as a conseque	enca of):					
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Box death cert	tend or us		0.	The Tol					-	
. 8	sed to	Part II. Other significant conditions of	contributing to death but not re-	sulting in the und	lerlying ceuse g	iven in Part I.	23b. Dld to	obacco use con	tribute to	the cause of death?
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S,	b ed by								O.4h Min	an autono dindino
of Vital Records,	ate has been signed by the attend, page 2 should be detached for us, Completed by Physician/	N - 12 - 124 Ta					24a. Was a perfor		ava	re autopsy findings allable prior to appletion of ceuse
Sec.	has be 2 s					THIT				death?
H H	s certificata has director, page 2 To Be Comp						1 U Y	es 2 No	1 [Yes 2 No
/ita	ertifi ector	25. Was case referred to medical examiner?	Hospital:				ath (Check only or	ne)		
of Vita	this cal dire	1 ☐ Yes 2 ☐ No	1 Inpetient 2L	ER/Outpatient	3LI DOA		Home 5 ☐ Resid)
Vision of Attending P	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of tnjury (Month, Day Year)	28b. Time of Injury	28c. Inju W	ork? ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurr	BC	
Division or Attending	within 24 hours efter deeth. To the Fureral Director: After thi completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined		home, farm, stree	et, factory, office	lasus S	28f. Location (S City or Tow	treet and Numbern, State)	er or Auma	l Route Number,
Hospital	O D	29a. Certifier 10 Certifying Pt	nysician: To the best of my kno	audadan daath a	anuscad at the	ime date and plac	a and due to the o	auso(s) and ma	nnor ar et	atod
P Hos	n 24 hc he Fun pletely edica		niner: On the basis of examina and manner stated.							
To the	To the composition of the compos	29b. Signature and title of cartifier	(Month, I	Day, Year)						
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	6	30. Name and address of person who	completed ceuse of death (Ite	m 23a) (Type, Pr	rint) Lh (1	FIL	ton n	nd	319	2.1
	State	31. Date filed (Month, Day, Year)	32. Registrar's Sign		1131,		, 1011	-01.	4.1.7.	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Year Physician LeeVarn Johnson Sept. 20 2000 3:58PM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Doctors Hospital Lanham Prince George's | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 7, 1949 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 M 2 □ F 334-42-8761 Yrs. Director Mississippi Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or flems 23a or 28a-f ahow adical Examiner must be notified at 1 Yes 2 No Director Maryland | Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages I and 2 should be filled within 72 hours efter death with Department of Heelith and Mentel Hyglone.
Important: If I fam 27 is marked other than "natural", or items 23a or amy injury or other than the word, the Medical Estation ment by 9322 Bandera St. 20706 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (2)No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indien, Bleck, White, etc. 11. Merital Status 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 X No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor Private 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 Robert Johnson Velma Levy 10 19e. Informant's Neme/Retetionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nettie R. Johnson - Wife 9322 Bandera St., Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removel from State Glenwood Cemetery 9/27/2000 Wash., D.C. 4 ☐ Donation 5 ☐ Other (Specify) re gLFuneral Service Liq 22. Name and Address of Fecility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 23a Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, about or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Examiner physician and s the buriei-transit or Attending Physician: The law requires that the deeth certificets be assocuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ℃Unknown s been signed by should be dete 2 Q 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? Hehality 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 8 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To After this 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. tnjury at Work? 1 Matural e the Hospital or Attending illnin 24 hours after death. Is the Funeral Director: Afte Ampletely filled in by the fun 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end placa, end due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signeture and title of confil 29c. License number 29d. Date signed (Month, Day, Year) 10 48213

Registrar

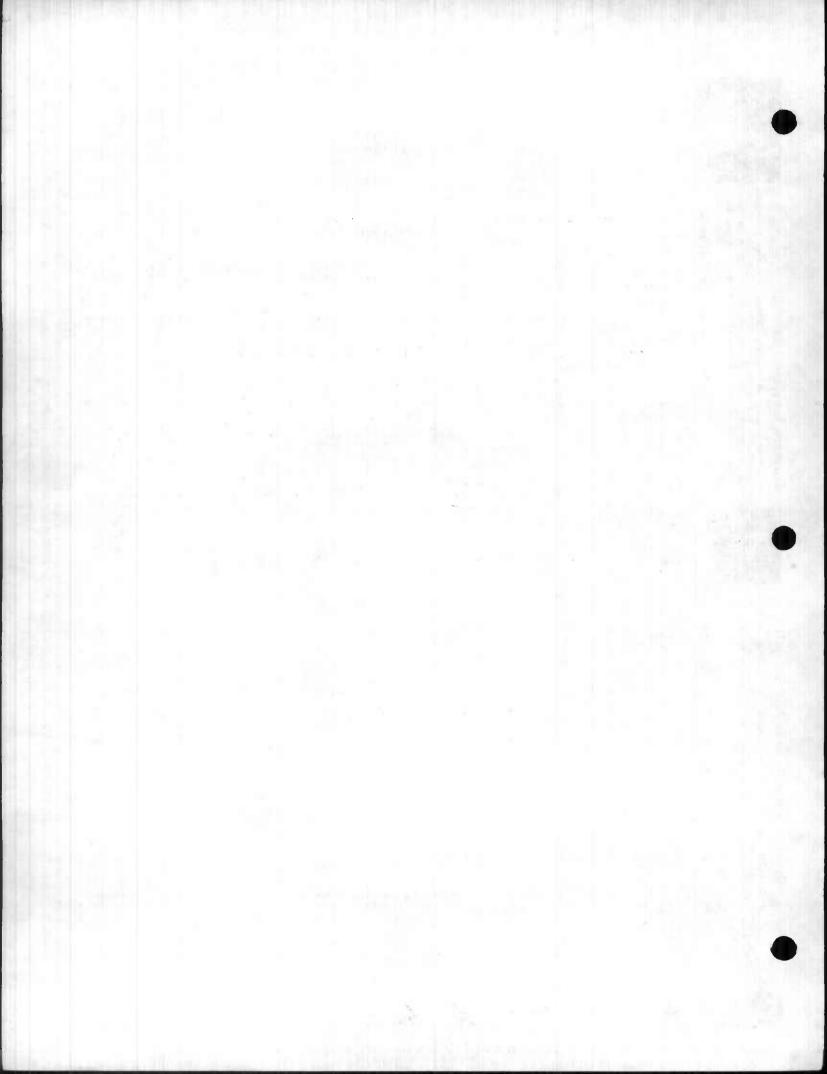
31. Dete filed (Month, Day, Year) SEP 2 5 2000

Neelan Ashan 4410 32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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landoner Hills MD 20784



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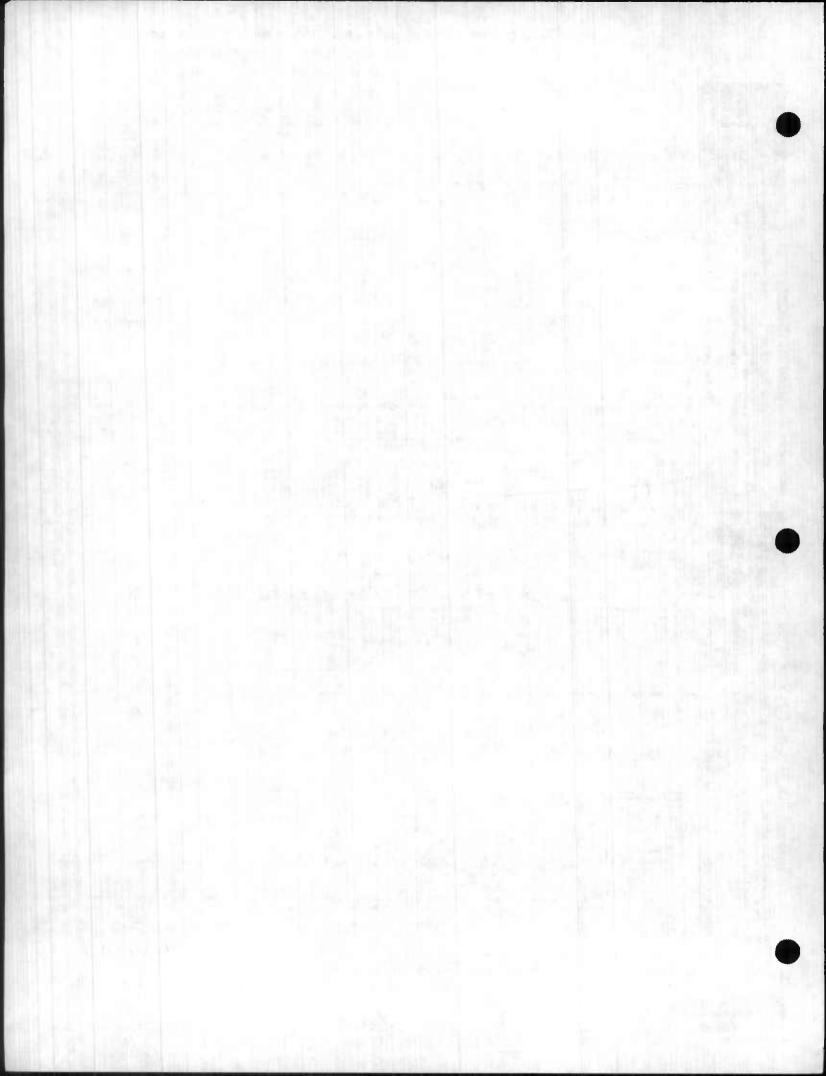
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	de Carille Name (II not institution aire street and sumber)					4b. City, Town, or	Location of Death	4c. County	of Death	
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5. Social Security Numb 578-72-9020		7. Age 2□ F	(In yrs. le	Mo	Under 1 Year onths Days		8. Deta of Birth (Month, Day July 9,		9. Birthpla Country Washir	ce (Stata or Foreign y) igton D.C
Usual Residence of Dec	cedant		4.				pary 7,	1733	WGDIIII	.6001. 2.0
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(Specify or Elamantary/Secondar 12th				Mail Handler				U.S. Postal Sen		
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Registrar

State of Maryland / Department of Health and Mental Hygiene 00 3226

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Examiner	4a Facility Name (II not institution, give PENINSULA REGIO	street and number) NAL MEDICAL (CENTE	NTER 4b. City, Town, or Location of SALISBURY					of Death 4c. County of Death WICOMICO			
Funeral Director	119-07-3837	7. Age (In yr.		if Under Months	Days	If Under 24 Hours	Min. (/	Pate of Birth Month, Day, Poruary			lace (State of try) W Yor	
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s or 28a-f sh be notified. Director	10e. Street and Number	,0	Dall	-	p Code			10	10g. Citizen of What Country?			
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trans.	19a. Informant's Name/Relationship (T) Ilene A. Richards								City or Town, State, Zip Code) MD 21801			
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		ompleted cause of death (to	em 23a) /	Type Drint					1 0	, ,		
	30. Name and address of person who come of the company of the comp	IDPA (0)	M 238) (I Cap D	51	504 R	501	ISRU	zy M	0 2/8	304	
Chada	31. Dete filed (Month, Day, Year)	32/ Registrar's Sig	nature		,			1 - 1 /	-			
State	CED 2 9 2000	mission	6	1	4.7							



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12:20PM James Thomas Jernigan September 26, 2000 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death St. Mary's 22159 Knight Court Lexington Park 6. Sex 1 M 2 F If Under 1 Year 9. Birthplace (State or Foreign Country) South Carolina 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Months Days Hours Min. Yrs. July 25, 247-78-7082 53 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22159 Knight Court 20653 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 No 1964— If Vês, Give Year or Dates: 1970 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Auto Body Mechanic 12 Automotive 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Willis James Jernigan, Jr. Kathryn Ruth Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nancy B. Jernigan, wife 22159 Knight Court, Lexington Park, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Chesapeake Crematory, Inc. 1 ☐ Burial XXCremation 3 ☐ Removel from State 9/29/00 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 21. Signature of Properal Service Licenses 22. Name and Address of Fecility Sterling Funeral Service 1601 Kenilworth Avenue, Washington, DC 20019 ant? Enfer the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, nock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death LARYNGEAL CARCINOMA Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or flea any injury or other traumetic event.

Baltimore, Maryland 21215-0020

Examiner Physician/Medicai þ Completed To

page 2 funeral Certification:

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that the death certificate be execu

Division of Vital Records, P.O. Box 68760, or Attending Physician: after death. Hospital 24 hours Funeral within 2

> 10 State Registrar

29e. Certifie

(Check only one)

Medical

				24a. Was en eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?			
25. Was cese referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpetient 3 DO	ath (Check only one) Home 5 Residence 6 Other (Specify)					
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury M	8c. Injury et Work? 1 Yes 2 No	28d. Describe how Injury occurred				
3 Sulcide 6 Could not be determined		ome, farm, street, factory	281. Location (Street end Number or Rural Route Number City or Town, State)					

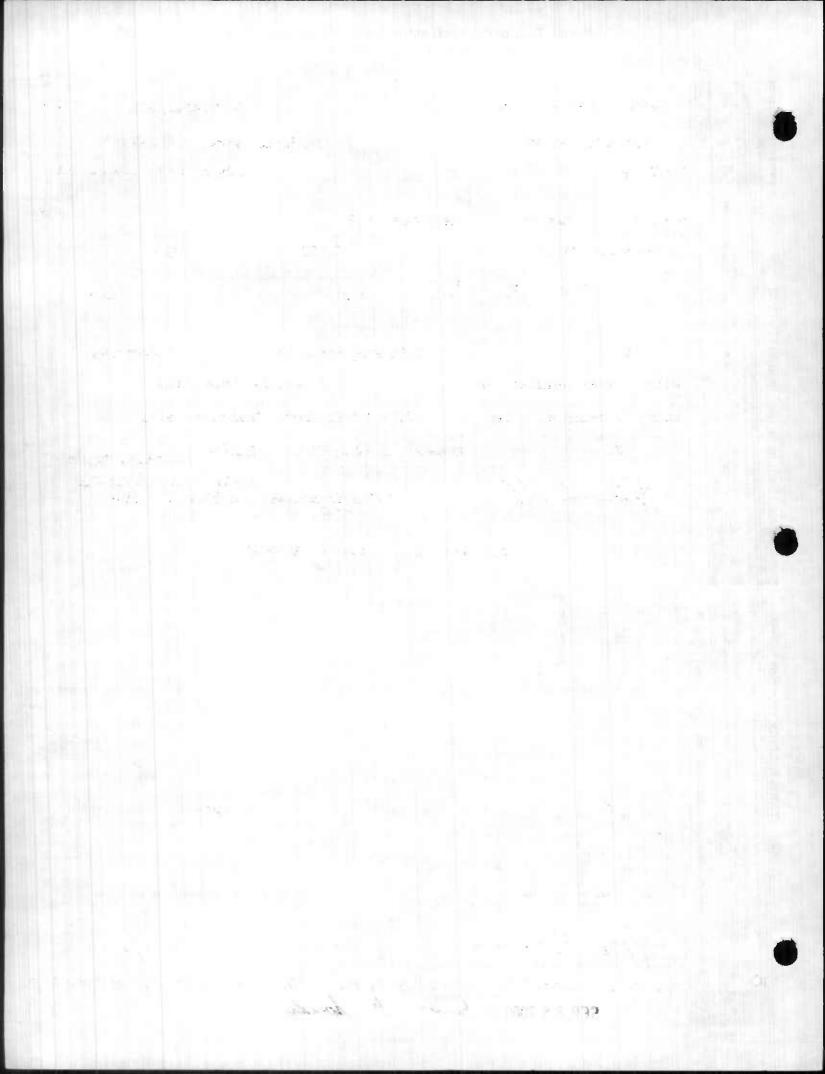
採 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Dev. Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

D40370 2000

110 Hospital Road, Suite 310, Prince Frederick, Maryland 20678 Dr. Peter Wisniewski

31. Date filed (Month, Day, Year) 32. Registrar's Signature **SEP 28** 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Day Year **Physician** Shizue Y. Keeran Selten en 17,2000 /Medical 4b. City, Town, or Location of Death 4c County of Death 4a Facility Nama (If not institution, giva street and number) **Examiner** Pince Geo chever 6 eggs Hospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 5, Birthplace (State or Foreign Country)
 Japan 5. Social Security Number Aga (In yrs. last birthday) **Funeral** 10 M 20 F 72 3155 85 Director 228 Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yas 2 ☑ No Director P.G. Forestville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20747 United States 1511 Asheville Road Funeral deeth . Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2000 No If Yas, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Black, Whita, etc. pemit. Peges 1 and 2 should be filed within 72 hours after Department of Heelth and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or ite any injury or other traumatic event. In a series. 1 Nevar Married 2 Married Saitimore, Maryland 21215-0020 1 Yas XXNo Specify Completed by 3 ☐Widowed 4 ☐ Divorced Japanese 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker Housewife 12 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be Fusa (UNKNOWN) Sotaro Yamazawa 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Toshi Wildfeuer (POA) 1511 Asheville Road, Forestville, Maryland 20747 20e. Mathod of Disposition 20b. Plece of Disposition (Nama of cemetary, cramatory or other place) Sept 26, 2000 20c. Location - City or Town, Steta XSBurial 2 Crametion 3 Ramovel from Stets 4 Donation 5 Other (Specify) Arlington National Cemetery Arlington, Virginia 22. Nama and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funaral Sarvice Ligensee Alexandria Ferry Road, Clinton, Maryland 20735 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intarval Between Onset and Death Physician Arterioscherotie Cardiovascular Discare Immediata Causa (Final disaese or condition rasulting in deeth) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disease or Injury that initiated avants rasulting in deeth) Lest Due to (or as a consequence of): P.O. Box 68760, Dua to (or as a consequence of): signed by the et d be detached for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records. Completed by 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tas 2 0 No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was casa rafarred to medical examinar? Be 26. Place of Death (Check only ona) Hospital: 1 Inpatient Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28a. Data of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending invastigation 1. Natural Hospital or Attending 24 hours after deeth.
 Funeral Director: After 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicide 6 Could not be detarmined 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) tely filled in by 4 Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.

State

To fire To the

Registrar

(Check only one)

29b. Signatura and titla of certifian

SEP 2 6 2000

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

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32. Registrar's Signeture

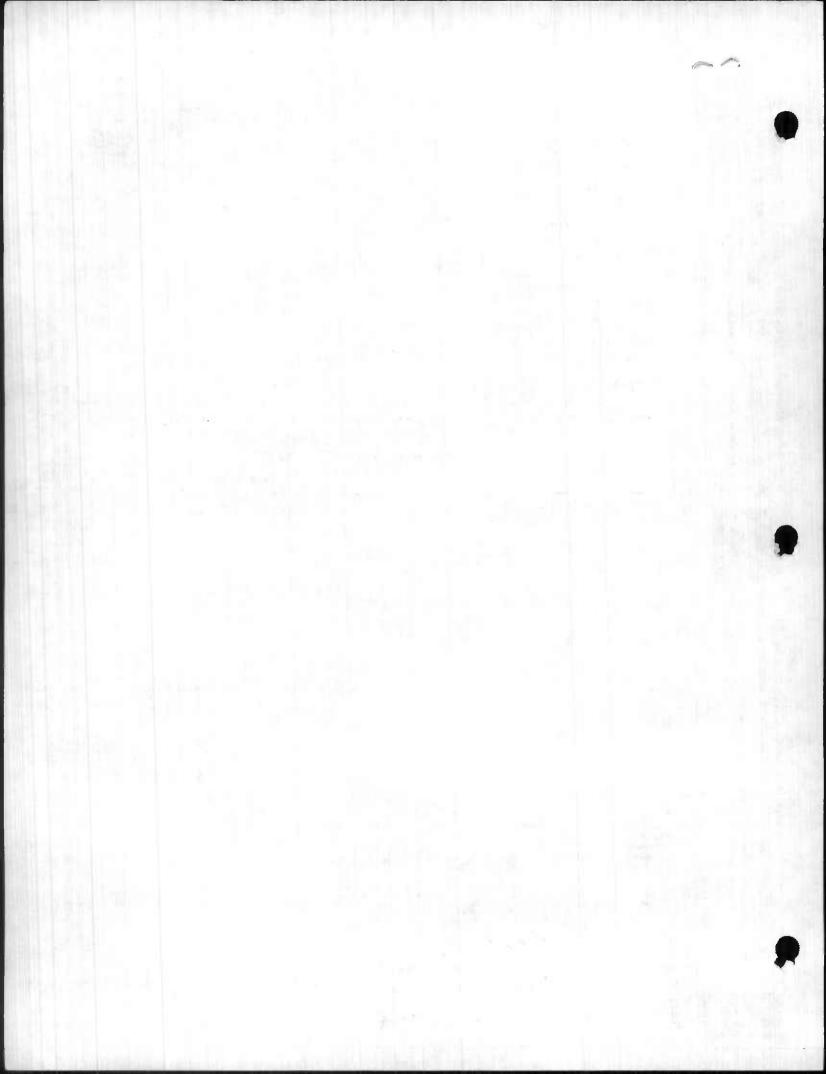
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Wedical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data end place, and due to the cause(s) and menner steted.

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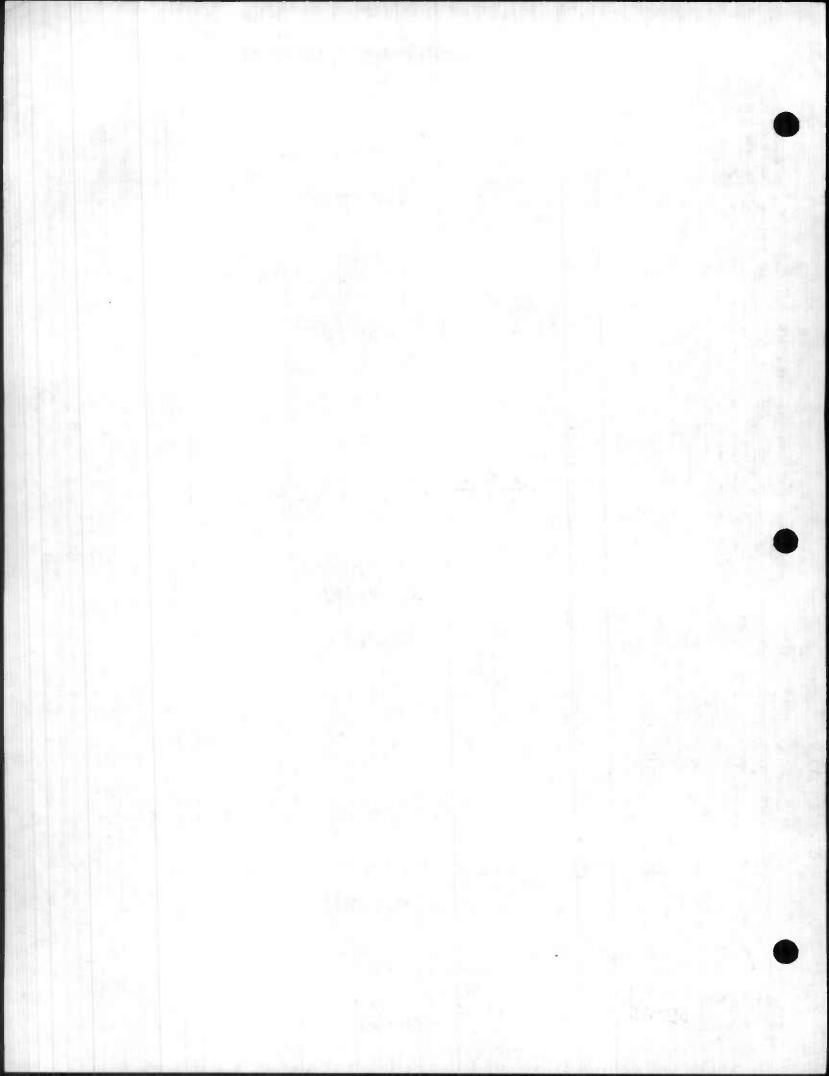
29d. Data signed (Month, Day, Year)



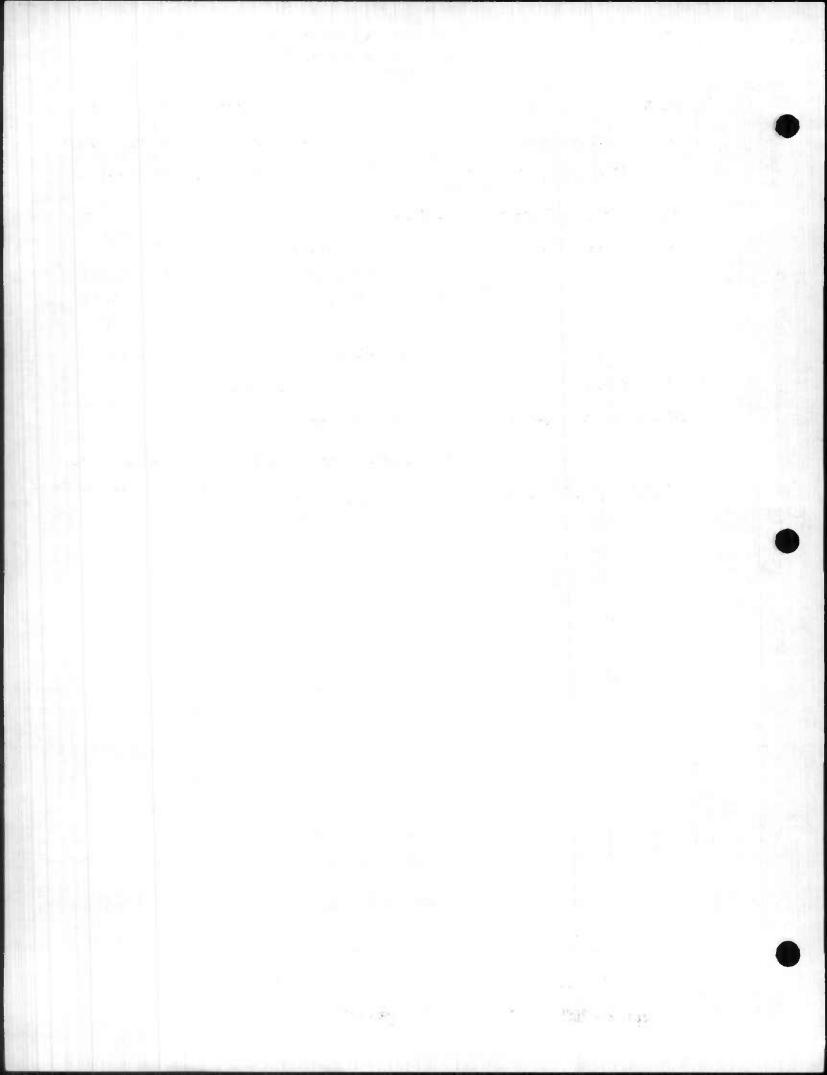
State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical	METTIE C. KIN	GSTON						09		2000	7:30 an	
/Medical Examiner	4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or								4c. County	-		
	1011 DANBURY DRIVE BOWIE								PRINC	E GE	ORGES	
al	5. Sociel Security Number 6. S	Sex 7. Age	(In yrs. lest birthde)) If Under			24 Hrs. 8	B. Dete of Birth (Month, Day			ece (State or Foreign	
or	585-26-4341	□M 2X0F 95	Yrs.	Months	Deys	Hours	Min.	6/28/		KENT		
	Usuel Residence of Decedent						P	0/20/	. 3 0 0	ICELT	OOKI	
	10e. Stete 10b. County	from the second	10c. City, Town or I	ocation						10	d. Inside City Limits	
to	MD. PRINCE	GEORGES	BOWIE								XXYes 2 □ No	
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by	3☐ Widowed 4☐ Divorced	If Yes, Give Yeer or Detes:		1 ☐ Yes	2 No	Specify:		Specify: WHITE				
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Be	J.K. WALKER											
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an	shock, or heart failure. List only	one cause on each line	ð.								Onset end Death	
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	30. Neme end address of person who											
	William DuBoyce		0 Mitche	ellvi	lle	Rd.	, Bow	vie, M	d. 207	/16		
ate	31. Dete filed (Month, Day, Year)	32. Registra	r's Signature									



ysician	_	. Decedent'a Name (First, Middle	, Last)		Cer	tificate of	Death	2. Dete of De Month			ime of Death
ledical	L		CNOTT	umborl			4b. City, Town, or L	SEPT.	23, 2000		35 am
aminer	4	e. Facility Neme (If not institution, 4901 NICHOLSON		umber)			RIVERDAL		- 1000	Of Death NCE GEOR	GES
eral ctor	5	Social Security Number 577 26 1116	6. Sex 1 □ M 2√F	7. Aga (In yrs. I	lest birthday) Yrs.	If Undar 1 Yaar Months Deys	If Undar 24 Hrs. Hours Min.	8. Date of Bi (Month, Di March 2	rth ey, Year)	9. Birthplace (Country) Virgini	Stete or Foreig
20	-	Usual Residence of Decedent Oa. Stete 10b. County		10c. City	, Town or Lo	cation					side City Limits
ral Director		Md. Prince	Georges		erdale						XYas 2□N
al Director		0e, Street end Number 4901 NIcholson	St.			10f. Zip Code	20737		10g. Citizen of What Country USA		
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Certificate of Death Reg. No.		046	0 (J
State of Maryland / Department of Health and Mental Hygiene	nn	322	51	70

			Cert	ificate of	Death	F	Reg. No.	0 (72200		
	1. Decedent's Neme (First, Middle, La			2. Dete of Des			3. Time of Death				
Physician	Helen C. Kostic			September 28,2000 415			4:15 AM				
/Medical	4a Facility Neme (If not institution, gir	ve street and number)			4b. City, Town,	or Location of Deeth					
Examiner					Filton		Cecil				
	Sunbridge Care Co	Sex 7. Age (In yrs.	last birthdev)	Elkton E				9. Birthol	ace (State or Foreign		
Funeral Director		1□M 2፟MF 82	Yrs.	Months Days		lrs. 8. Dete of Birth in. (Month, Day November	oth ay, Year) 9. Birthplace (State or Foreign Country) 18,1917 Pennsylvania				
pue *	Usual Hesidenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City										
vith the Maryl or 28a-f aho be notified a	Maryland Cecil North East							1 ☐ Yes 2 📉 No			
with the		10g. Citizen of 1									
w 23	77 Kirks Mill Lar	12. Wes Decedent Ever in U	IS 13 W	21901	Hispanic Orlgin?	(Specify Yes or No-	United 14. Rad	STATE e - America			
1215-0020 within 72 hours after death with the Manyland and the "natural", or items 23s or 28s-f show the Madical Examination must be notified at propleted by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	lf '	Yes, specify Cul ☐ Yes 2 🔯 No	uban, Mexican, Puerto Rican, etc.)		Black, White, etc. Specify:		etc.		
DOUR PARTY	3 ₩ Widowed 4 Divorced	Yeer or Dates:						Whit			
aryland 21215-0020 should be filed within 72 hours at not Mentel Hygiene. Immerical other than "natural", or immetic event, ine Medical Example To Be Completed by I	15. Decedent's E (Specify only highest gr		(Give k	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				usiness/Ind	ustry		
2121 within lene. then	Elementery/Secondary (0-12)	College (1-4or 5+)			9d)						
filed w Hygler then the mr, m	12		Homemaker						In her own home		
Maryland d2 should be file h and Mentel Hy rie marked oth treumatic event To Be (7. Father's Name (First, Middle, Last)				18. Mother's N	3. Mother's Name (First, Middle, Maiden Sumame)					
should be not Mentel or marked or umarked or	Joseph Moore			Susan Kane							
Aar 2 sho and is m	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing	Address (Street	eet and Number or Rural Route Number, City or Town, State, Zip Code)						
10re, Maryland 212 gas 1 and 2 should be filed withi t of Health and Mentel Hyglene. If itsm 27 is marked other than or other treumatic event, the M	Arlene McCloskey	/ daughter	77 Kir	ks Mill	Lane,	North Eas	t. Mary	land :	21901		
other other	20a. Method of Disposition	20b.	Place of Disposi cametery, cremi	ition (Neme of	909)	Dete	20c. Location				
Baltimore, Noemit. Pagas 1 and Poperturent of Health mportant: if Itam 27 my injury or other tance.	1 Burial 2 Cremation 3 C	Jemovei from State			U	ctober 3,	Spring	field	,		
altim nit. Par antmen ortant: injury	21. Signature of Funeral Servica Lice	000			Cemetery	2000	Pennsy	Ivani	.a		
Baltimo permit. Pag Department Important: If any injury or page.	21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Oliver H. Bair Companies, 8500 West Chester Pike Upper Darby, Pennsylvania 19082										
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the dee	th. Do not enter	the mode of dy	ring, such es card	liec or respiretory er	rest,		Approximate Interval Between		
Certificate be assecuted reducing physician and usa as the burial-transit	disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injiteted events	c. Cerebro	or es e conseque	ence off: Hear- enca of):	Diseas Fai Accide	e lure nt		1			
BOX (ath certif ttending or usa as		d						1	the source of death?		
tha d	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause				Iven in Part I.	bbacco use contribute to the cause of death?					
£ 20 .						_	Yas ZEINO	3 Prot	abiy 4 Onknown		
requirements should							Was an autopsy performed? 24b. Were autopsy findire eveilable prior to completion of cause of deeth?				
Rec e lew has b											
						101	res 20 No	1 1 1	Yes 2 No		
of Vital Physician: The this certificate ral director, pag.: To Be Co	25. Wes case referred to medical examiner?	111-1				Death (Check only o					
_ 5 00	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient			g Home 5□ Resid			1)		
Attending Pt r death. ector: Atter it by the funeral iffication:	27. Manner of Death 1/D-Maturel 5 Dending 2 Accident Investigation	28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. In			njury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No			rred			
Division of the or attending P is a ther death. at Director: After the in by the funerated in by the funerated Certification:	3 Suicide 6 Could not b determined	286 Place of Injury - at nome tarm street factory office 201. Locati				281. Location (S City or Tox	ion (Street and Number or Rural Route Number, or Town, State)				
Division of To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director. After thi completaly filled in by the funeral Medical Certification: 7											
ithin on the small	29b. Signature and title of certifier	nse number		29d. Date signed (Month, Day, Year)							
6414											
	1000	accel	~ ~	D26183			nd. 21921				
(2)	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, P	rint)	L EIN	ita n	11 1	1921			
	31. Date filed (Month, Day, Year)	32. Registrar's Sign	II NO	17437	ELI	Ton /	w. d	121			
State Registrar	CED 9 2 20	V	4	lone	11						

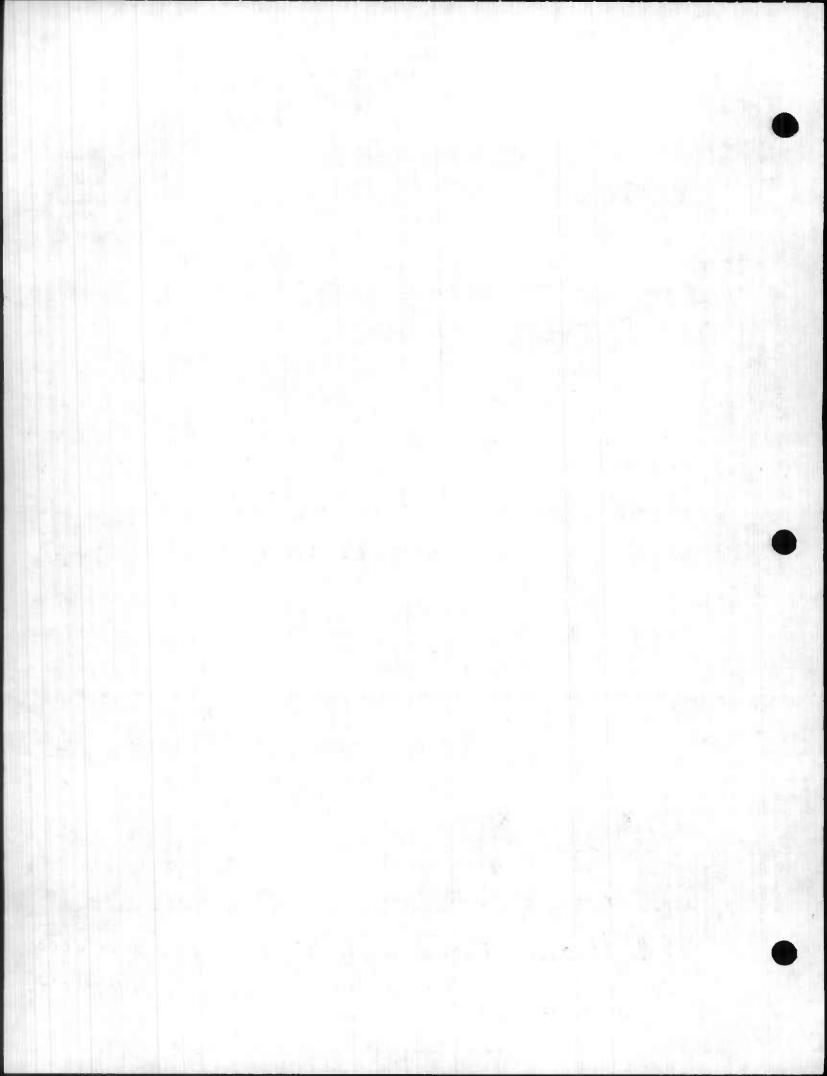
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State of Maryland / Department of Health and Mental Hygiene 00 32257

PLACEMENT	1. Decedent'a Name (First, Middle, Last)									3. Time of Death					
Physician /Medical Examiner	Stanley Eugene Koppenhaver								August 18	, 2000	Yeer	2115			
		me (If not institution,			- 6			4b. City, Town, or L		4c. County	of Death				
	Dorch	Dorchester Memorial Hospital								Dorchester					
Funeral Director	5. Social Secu 171–20	-6164	3. Sex 1 X ☐ M 2☐ F	Name of the state			1 Year Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (Str. Country) Feb. 17, 1925 Pennsylvar			ce (State or Foreign y) vlvania			
1	10e. Stete	10b. County		10c. C	ity, Town or L	ocation					100	d. Inside City Limits			
reho led a	MD Dorchester Cambridge											1X Yes 2 No			
liers 23s or 23s-f sho liner must be notified at Furneral Director	10e. Street and	d Number				10f. Zip	Code			10g. Citizen of	0g. Citizen of What Country?				
0	1/1/6 Ca	mbridge Bel	tway				216	513		United S	tates				
Funeral	11. Marital Sta		12. Wes Deced	dent Ever in l	J,S. 13.	Was Deced		dispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Rac	e - Americai				
by	_	Married 2 Marrie		2 N23 -	46	1 ☐ Yea 2			o Hican, etc.)	Specif	ck, White, et y: Whi				
Completed		15. Decedent's	Education		16a. Deci	16a. Decedent's Usual Occupation (Give kind of work done duning most of working life. DO NOT use retired)					usiness/Indu	ıstry			
du	Elementery/Secondery (0-12) College (1-4or 5+)														
	12	amo (Finat Middle 1)	and)		Tool	& D	ie .	Machinist 18. Mother's Nam	no (First Middle	Wester		etrie			
Be	100	ame (First, Middle, Li Unknown	131)					Unknow		Melden Surnar	110)				
10	100 Informan	t'a Name/Relationshi	n (Time Print)		10h Mail	lina Addrage	(Stroot		Rural Route Number, City or Town, State, Zip Code)						
200		ld F. Koppe						ltway, Camb			, State, Zip C	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
- Constant	20a. Method o			20b.	Place of Disp	osition (Nam	ne of		Date	20c. Location	City or Tow	m, State			
		2 ☐ Cremation 3 tion 5 ☐ Other (Spe		tate	cemetery, crest. Shor				8/21/00	Hurlock,	Maryla	and			
		of Funeral Service Li						ess of Facility	acility						
oue	Mi	chael F. Est	cow per DVR		F	ramptom- O Box 4:	-Hawl	kins-Eskow ederalsburg	, MD 21632	2		3.			
	23a. Part1. Er shock, or	nter the disease, or c r heart teilure. List o	omplications that can nly one cause on ea	used the dea ch line.	th. Do not er	nter the mode	e of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximete Interval Between			
cian	Inner dieta Ca	was (Final	0	Ruptured Aortic Aneurym 24 ho											
lical iner	Immediate Ca disease or cor resulting in de	ndition	a	a reality of the state of the											
5				Due to	or as a conse	equence of):									
Examiner			b	b											
Exa	Sequentially li	st conditions, to immediate		Due to (or es a consequence of):											
edicai	Cause (Disease or injury that initiated eventa resulting in death) Last C. Due to (or as a consequence of):														
2			d												
d by Physician/M	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i							ven in Pert I.	23b. Dld 1	obacco uae co	entribute to	the couse of death?			
hys		17							1 Yes 2 No 3 Probably 4 Unkno			ably 4 🗆 Unknown			
by P															
should	1 12								24a. Was en autopsy performed? 24b. Were autopsy feverlable prior t			ilable prior to			
S O								completion of death?		opletion of cause eath?					
Com									1 □ Yes 2 No		10	Yes 2 No			
To Be C	25. Wes case examiner?	referred to medical						26. Place of Dea	ith (Check only o	ne)					
	1 Yes	2 No	Hospital:	Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing					g Home 5 ☐ Residence 6 ☐ Other (Specify))			
a Director: After the lied in by the funeral Certification:	27. Manner of		28a. Date of (Month)	Injury Day Year)	28b. Time Injury	of 2	8c. Inju	ry et rk?	28d. Describe I	now injury occu	rred				
	2 Accide	ent investiga	ition	be age there of brings. At home from street feeting office.			Yes 2 No								
	3 Suicid		ed 286. Place					28f. Location (Street and Number or Rural Route Number, City or Town, State)							
edical	29e. Certifier (Check on	1 Certifying 2 Medical Ex	Physician: To the baseminer: On the base	sis of examin	owledge, dee ation and/or i	th occurred envestigation,	et the ti	me, date and piaca opinion, death occu	, and due to the rred at the time,	cause(s) end m dete end pleca,	enner as sta end due to	ited. the cause(s)			
Med	one)	dond sitto of an elife	and menn	er steted.		200	1 inne	se number		29d Date sign	ed (Month C	lav Yearl			
3	29b. Signeture and title of certifier						(37 10	29d. Date signed (Month, Day, Year)			2000				
		milian lan						1008	28 August 21, 2000 - Cambridge, MD 21613						
	30. Name and	address of person w	ho of pleted cause	of death (Ite			10	5K	Cambo	then	ma	21613			
	001	a contraction	Joan	- I		INKI	171		allel	199K	עווע	5101-			
State	31. Date filed	MONIN CALL TOWN	2000 32. He	girtrar's Sign	ature	Eq 1		. 5							



		State of Maryland /	Certificate of		F	Reg. No.	0 32268				
Physician /Medical	Decedent's Neme (First, Middle, La: LOUIS ANGELO LOZU		Month SEPT.								
Examiner	4e Fecility Neme (# not institution, give 2250 FLAG COURT	e street and number)	cation of Deeth	th 4c. County of Deeth ANNE ARUNDEL							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Var H Under 1 Year H Under 24 Hrs. 1 Moriths Deys Hours Min.				8. Date of Birth Month, Day Jan I	Birth 9. Birthplace (State or Foreign Country) Washington, DC					
nyland thow Lat	Usuel Residence of Decedent 10a. Stete 10b. County	10c. City, To		10d. Inside City Limits							
on the Ma or 28a-fa be notified	Md. Anne Aru	ndel Oder			1 Yes 2 □ No						
	10e. Street and Number 2250 Flag Court		10f. Zip Code 21113			10g. Citizen of W USA	hat Country?				
	11. Merital Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Detes:	**	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify: 14. Raca - Ameri Bleck, White							
Maryland 21215-0020 d 2 should be lited within 72 hours at the and Mental Hyglene. The marked other than "natural", or traumatic event, the Medical Exam To Be Completed by I	15. Decedent's Ec (Specify only highest gre Elementery/Secondery (0-12)	de completed) College (1-4or 5+)	a. Decedent's Usuel Occup (Give kind of work done life. DO NOT use retire	pation during most of works d)	ing	DC Fire Dept.					
be filed other event, I	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surneme)								
Vlar Menta Menta milito ev TO B	Louis Angelo Loz	upone	Gi	Gilda Pace							
Mary 12 sho	19a. Intorment's Name/Reletionship (Type, Print) 19	9b. Meiling Address (Street same as 10e	end Number or Rura	al Route Numbe	er, City or Town,	State, Zip Code)				
Baltimore, I norm: Pages 1 and Opportment of Healt importent. It Item 21 iny Injury or other 1 ince.	Jacqueline Lozupo 20e. Method of Disposition 1	20c. Location - 0	c. Location - City or Town, State								
Him Park	4 Donetion 5 Other (Specify	St.	Mary's Ceme		. 25,20	00 Wash	ington DC				
Balt permit Depart Import any in	21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Robert E. Evans Funeral Home, 16000 Annapolis RD., Bowie, Md. 20715										
Physician	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Deeth										
/Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth) ACUTE MYFWGENOUS LEUKEMIA 1 YEAR. Due to (or es e consequenca of):										
. Box 68760, deeth certificate be executed e ettending physicien end ad for use as the buriel-transit	Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of):										
T = 0											
deeth deeth od for sicia	Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying cause gi	ven in Pert I.	23b. Dld t	lobacco uae con	tribute to the cause of death?				
is, P.O. Box es thet the death certigned by the ettending be deteched for use by Physician/M			10	1 Yes 2 No 3 Probably 1 Unknown							
aw requir				en eutopsy med?	24b. Were eutopsy findings aveileble prior to completion of cause of death?						
= F # d 0					101	res 2XXVo	1 ☐ Yes 2 ☐ No				
Vita clan: entific ector,	25. Was case reterred to medical examiner?	Hospitel:	C#	26. Piece of Death	****						
the this plant in the party of	1 Yes XXNo 27. Menner of Death 1 XNeturel 5 Pending	28a. Dete of Injury (Month, Dey Year)	me XX Residenca 6 □Other (Specify) 28d. Describe how injury occurred								
or Attendation of Att	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	M 1 ☐ Yes 2 ☐ No 28e. Pleca of Injury - At home, tarm, street, tectory, offica bullding, etc. (Specify) 28t				28t. Location (Street end Number or Rurel Route Number, City or Town, Stele)					
To the Hospital or within 24 hours afte To the Funeral Din completely filled in Medical Cert	29a. Certifier (Check only one) Check only one										
Vithin To the complete Me	29b. Signeture end title of certifier 29d. Date signed (Month, Dey										
	Doorgog					9/23/00					
(14)	30. Neme end eddress of person who	completed cause of death (Item 23st 5 / TER , 40/ A	a) (Type, Print) L BROADWAY	, BALTI	MORE,	MD 2	1235				
State Registrar	SEP 2 6 2000	22. Registrar's Signeture	. Snav								

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B.K.S	1 10430	State of Maryland		of Health and M	•	aiene oo	00000			
CHARLENE Y	VONNE LOVELY 23a, 27 per me G790 12		Certificate			Reg. No.	32269			
	1. Decedent's Name (First, Middle, Las			2. Date of De		3. Time of Death				
Physician /Medical	Charlene	Yvonne	Lovely		SEPT.	30. 2000	2236 PM			
Examiner	4a Facility Name (If not institution, give			4b. City, Town, or Lo	cation of Deet	h 4c. County of D				
NA.	DOCTORS COMMUN		ast hirthday) If Under 1	LANHAM Year If Under 24 Hrs.	0 Date of Bi		GEORGES			
Funeral Director	5. Social Security Number 6. S 212-08-5525	9X 7. Age (In yrs. I		Days Hours Min.	8. Dete of Bit (Month, De	ay, Year) 9.	Birthplace (State or Foreign Country)			
	Usual Residence of Decedent									
death with the Maryland ma 23a or 28a-f show r must be notified at	10a. Stefe 10b. County 10c. City, Town or Location 10d. Inside City Yes									
vith the Mai n or 28e-f s be noutled	Maryland Prince	Georges	New Carroll							
uth with the Maryla 23a or 28a-f shouls to notified at	10e. Street and Number 5406 - 85th Aver	nie. Ant 22	10f. Zip C	0784	47.7	10g. Citizen of What				
offer death v Heme 23e	11. Marital Stetus	12. Was Decedent Ever in U.		nt of Hispanic Origin? (Spot Cuban, Mexican, Puerto	ecify Yes or No		American Indian,			
9 5 7 7	Never Married 2 Married	Armed Forces?			Rican, etc.)		Vhite, etc.			
0 5 7 0		If Yes, Give Yeer or Detes:	1 ☐ Yes 🍇	XNo Specify:		Specify:	Black			
1 21215-002 ed within 72 hours ygiene. ygiene. t, re-kredienel., Completed by	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Decedent's Usual (Give kind of work life, DO NOT use	done during most of work	ing	16b. Kind of Busine				
2121 Jiene. r than r	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)	Program S			Services	s Community			
aryland 2 should be filed and Mental Hygia marked other imatic event, if			110gram 0		ame (First, Middle, Maiden Sumame)		3			
ylan ylan ouid be ouid be mental ouid be arked o atto ouid be arked o	Willie	Lovely, Jr.		Vivian	Green					
Baltimore, Maryland : semit. Pages 1 and 2 should be filed bepartment of Health and Mental Hypoportant: If New 27 is marked other iny injury or other traumatic event, once.	19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailing Address (Street and Number or Run	al Route Numb	per, City or Town, Star	le, Zip Code) 20784			
1 and 1 health Health or 27 ther tr	Cynthia Ann Lovel				ton, Maryland					
Baltimore, Nomit: Peges 1 and Department of Health Important: If Heat 27 any injury or other transfer.	20a. Method of Disposition 1 🖾 Burial 2 🗆 Cremation 3 🗆	Removal from State	laca of Disposition (Name emetery, crematory or oth	or place) Oct. 5	Date 2000	20c. Location - City	20c. Location - City or Town, State			
Itira it. Pe rtant: njury	4 Donetion 5 Other (Specify) FC	rt Lincoln	Cemetery !	Brentwood, Maryland					
Balt permit. Depart Importu	21. Signature of Funeral Service Licen	See	orton Company Morticians, In			ic.				
	23a Part Foter the disease or comp	dications that caused the death	600 Ken	nedy Street,	N.W.;	Washingto	on, D.C. 20011			
Physician	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each line.	. Do not onto the mode	or aying, basin os sardias.	or respiration,		Interval Between Onset and Death			
/ /Medical	Immediate Cause (Final disease or condition a CARDIAC ARRYTHMIA ASSOCIATED WITH MITRAL VALVE PROLAPSE									
Examiner	resulting in death)		ras a consequenca of):	WITH HITKAL V	ALVE FROM	LAFOL				
ovecuted in and instrement		b								
60, be execut iclan and burial-tren	Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):								
a price & O	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
Box 687 death certificate e attending phys of for use as the siclan/Medic										
Box atth cent attending for use		d								
	Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.			23b. Did	tobacco use contrit	bute to the cause of death?			
P.O. d by the deteche	Bear Art September 1			1 Yes 2 No 3 Probably 4 Unknow						
ords, P.O. I requires that the de- een signed by the a hould be deteched to			U.A.C.	24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death?						
cord v require been s should										
Hess hess			٨.	1 Dives 2□ No						
Vital Piclen: The certificata rector, pag	25. Was case referred to medical	1 (1 Yes 2 □ No 1 0 Nes 2 □ No 2 0 No 1 0 Nes 2 □ No 1 0 Nes 2 □ No 1 0 Nes 2 □ No 1 0 Nes 2 □ No 1 0 Nes 2 □ No 1 0 Nes 2 □ No 1 0 Nes 2 □ N								
A 5 5 0	examiner? 1)∑ Yes 2 □ No	Hospital: 1 Inpatient 2 XER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
on of ding Physical ding Physical distributions of the times of the ti	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 1980 Injury	. injury at Work?	28d. Describe how injury occurred					
Vision Attending or death. ector: Atte by the fune	2 Accident Investigation 3 Suicide 6 Could not be		М	1 Yes 2 No						
Division of attending P after death. To Director: After to die in by the funers Certification:	4 Homicide determined					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Ne Hospi n 24 hound Ne Funer pletely fill edical	(Check only 2 Medical Examone)	iner: On the basis of examinat and manner steted.	ion and/or investigation, is	my opinion, death occur	ed at the time	, date and place, and	due to the cause(s)			
To the within To the comp	29b. Signature end fitte of certifier	, 11	29c. License number			29d. Date signed (Month, Dey, Year)				
	1 Theoline 1	1. Kery-	us	O.C.M.E	OCT. 1, 2000					
(5)		completed cause of death (tem 23a) (Type, Print)								
0	THEODORE!		111 Penn St	reet, Balti	nore, M	laryland 2	1201			
State Registrar	31. Date filed (Month, Day, Year) OCT 0 4 2000	32 Hodistrar's Signal	G. Some	6						
5.01.41	001 4 - 2000	/	/ //							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Data of Death Dey **Physician** LYDDANE CAROLYN DONNELLY \$eptember 28,2000 01:00AM /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 6012 New Forest Court Waldorf Charles 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
June 7, 1924 7. Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign 1 M XXX **Funeral** Months Deys Hours Min. 579-22-6372 76 Yrs. Washington, D.C Director Usuel Residence of Decedent the Meryland 10e. Stete 10b County 10c. City. Town or Location 10d. Inside City Limits ?? is marked other than "natural", or flams 23a or 28a-f ahow traumatic evant, the Med cal Examinar must be notified at Maryland 1 Yes 2 No Charles Waldorf Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 6012 New Forest Court, Apt#1 20603 Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 13. Was Decedent of Hispenic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yas 2 🕅 No If Yes, Give Yaar or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White P 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry itted within 7. I Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) Dentist Secretary 17. Fathar's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) e 2 should be f and Mental I Bessie Birch James David Donnelly 19e. Informent's Neme/Reletionship (Type, Pnnt) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 sh Department of Health and Important: If item 27 is m 3 any injury or other traum? Joseph A Lyddane/Husband 6012 New Forest Court, Apt.1, Waldorf, MD 20603 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 20a. Method Disposition 1 X Burla 2 Cremation 3 Removal from S 10-02-2000 Chapel Point, MD 5 Dther (Specify) Ignatius Cemetery 4 | Do 21. Signal 22. Name and Address of Fecility The Huntt Funeral Home, Inc. mew M00053 P.O. Box 156, Waldorf, Maryland 20604 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final Cirrhosis of Liver disaesa or condition resulting in death) Examiner Due to (or es e consequence of): Examiner sician end Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): the attanding physician thed for use as the burie Box 68760 Physician/Medical thet initieted events resulting in death) Last Due to (or es e consequenca of) been signed by the s should be detached Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of causa of death? Completed 24a. Wes en eutopsy page 2 should has 1 Yes XX No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home *** Nursidance 6 Other (Specify) Hospitel: 1 tnpatient 2 ER/Outpatient 3 DOA 1 Yes XXX 2 this 28c. Injury et Work? Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Attending X1XXVeturel 5 Pending Investigation deeth. 1 Yes 2 🗆 No 2 Accident I or Attendi after deeth Director: A 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a To the Funeral D All Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated.

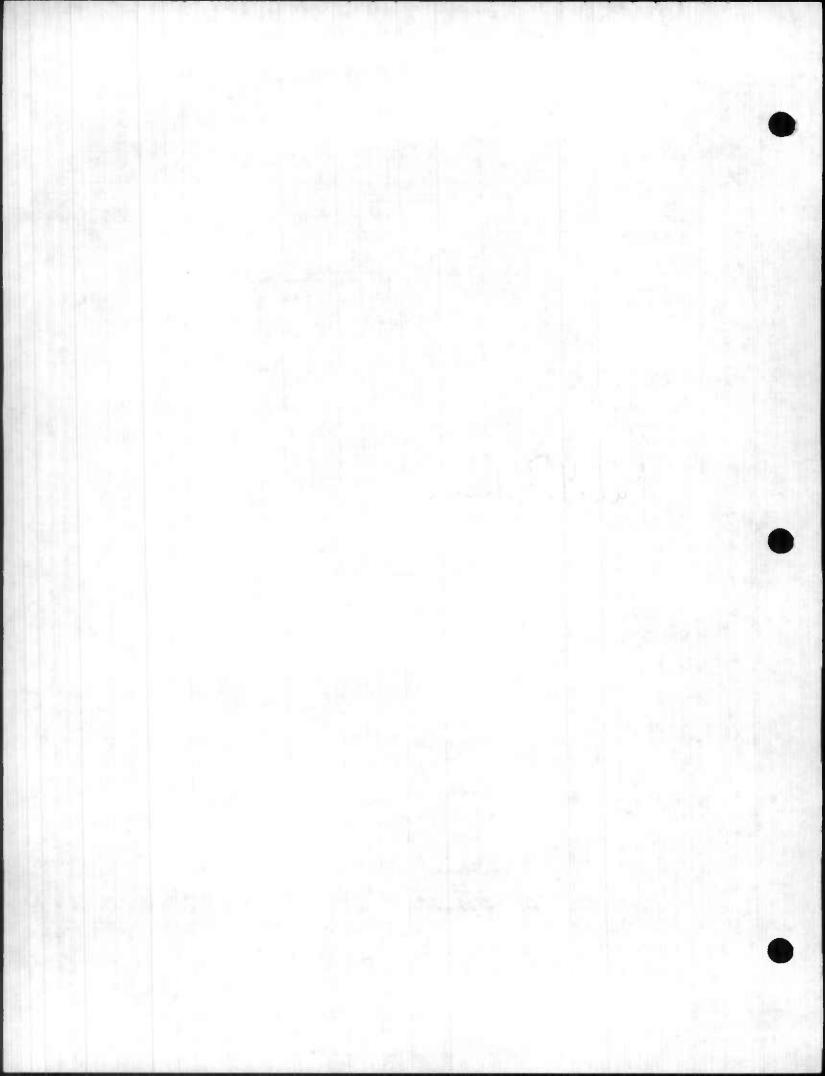
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end manner stated. 29e. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier September 28,2000 D28352 30. Nama and address of person who completed cause of deeth (item 23a) (Type, Print) Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646 31. Deta filed (Month, Dey, Year) 32. Registrat's Signatura

DHMH 16 Rev 6/95

State

Registrar

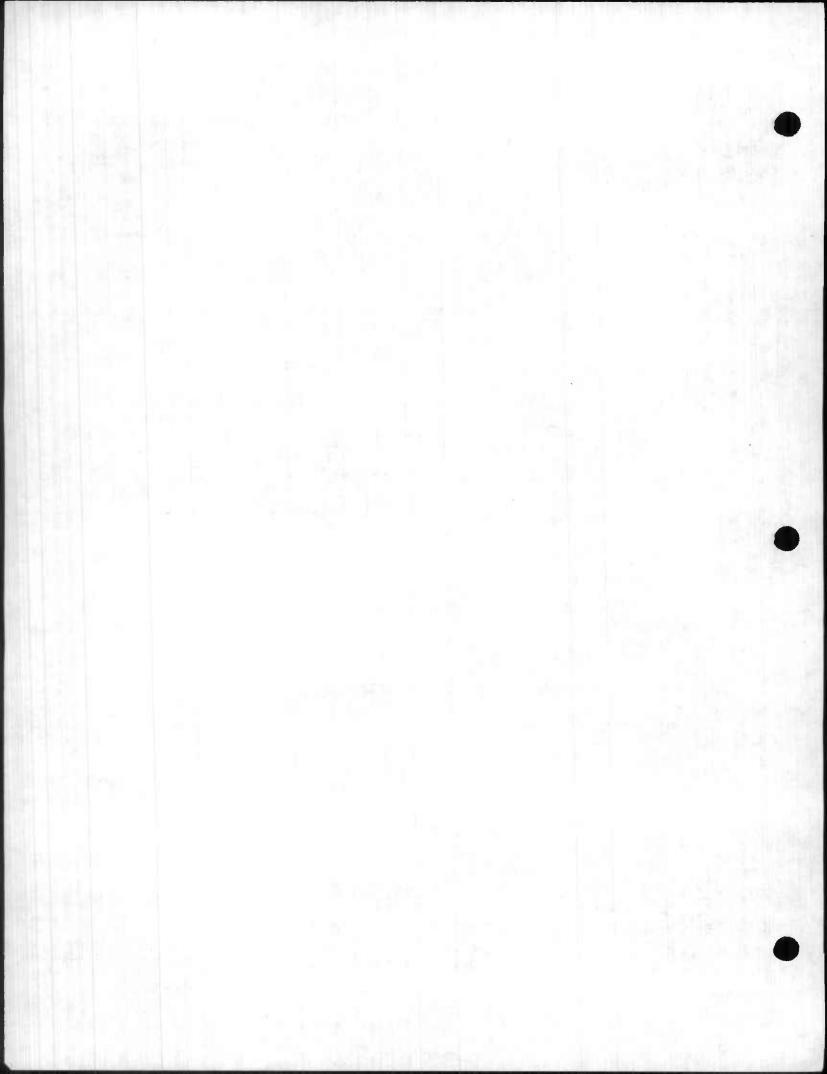
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State of Maryland / Department of Health and Mental Hygiene 000000

Joseph David :	State of Maryland / Department of Healt 23a,27, 28a,b,c,d,e,f per me G788 10/25/00 Fertificate of Dea	th and Mental Hygiene 00 32271
	1. Decedent's Neme (First, Middle, Last)	2. Dete of Deeth 3. Time of Death
Physician	Joseph David Linton	October 07, 2000 1030 am
/Medical Examiner	4a Facility Neme (If not institution, give street end number) 4b. City	y, Town, or Location of Deeth 4c. County of Deeth
		on Bridge Frederick
Funeral	Months Dave Hou	nder 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9. Birthplaca (State or Foreign Country) May 3, 1962 Maryland
Director	215-84-3589 18☐M 2☐F 38	May 3, 1962 Maryland
pue/	10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits
Man meret	Maryland Frederick Union Br	ridge 1□Yes 2△No
ith with the Maryler 23a or 28a-f ehow ust be notified at	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
23a W	10111-B Clemsonville Rd.	21791 U.S.A.
20 site death v or frems 239 since must	11. Maritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispania If Yes, specify Cuben, Merital Stetus	c Origin? (Specify Yes or No- xican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc.
020 urs aftu	1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Spe Yeer or Detes:	specify: White
d 21215-0020 filed within 72 hours after death with the Maryland hygiene. ther than "natural", or ferma 23a or 28a-1 show but, the Medical Examina must be notified at a Completed by Funeral Director		
215 hin 73	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)	
1 21215-0 ed within 72 ho ygiene." neturn or then "neturn it, the Medical	12 HVAC technician	county gov't.
be filed ntal Hygin of other event, it		Aother's Name (First, Middle, Maiden Sumeme)
aryian should be and Mental marked o umatic eve	Joseph Martin Linton	Barbara E. Fogle
Maryis	19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end No. Karen D. Linton/wife 819C Stratford D.	umber or Rural Route Number, City or Town, Stefe, Zip Code) r. Frederick. MD 21701
other tr	20a. Method of Disposition 2 Department of Cametery, cremetory or other placa)	Dete 20c. Location - City or Town, Stete
Peges nent of I	Manual 2 Cremetion 3 Deemover from State	
	4 Donetion 5 Other (Specify) 21. Signator of Funeyal Servica Licensee 22. Name end Address of F	
Bait permit. Departr Importa any inju	athanie (). War Plen 11802 Libert	nartzier runerar nome
	23a. Part1. Enter the disease, or complications that caused me deeth. Do not enter the mode of dying, suc shock, or heart failure. List only one cause on each limit.	
Physician /Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth) a. CUNSHOT WOUND OF HEAD Due to (or es e consequence of):	Onset end Deeth
3760, site be executed sysician and the bunk-trensit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	
ds, P.O. Box 68760, ires that the death cartificate be existed by the attending physician dbe detached for use as the burial by Physician Medical E	thet initiated events resulting in deeth) Lest Due to (or es e consequence of):	
Box eath carting attending for use a		Death 20th Did tobacco upp contribute to the course of death?
P.O. do by the dotte that do by the letached	Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in I	Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
S, P es that igned t be det		
s been 2 should		24e. Wes an autopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of death?
The law ate has pege 2		1 Yes 2 No 1 No 2 No
f Vital F yelden: The sis certificate director, pee	25. Was case referred to medical 26.	Piece of Deeth (Check only one)
Of Vita Physicien: this certific ral director,	1 No Pospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 41	□ Nursing Home 5 □ Residence 6 □ Other (Specify) at scene
On o Ming Ph After th funeral	27. Menner of Death 1 Netural 5 Pending Pending See Dete of Injury 28b. Time of A Work? 1 Netural 5 Pending Formal A Year)	28d. Describe how Injury occurred subject shot self
Vision Attending or deeth. ector: After by the fune	2 Accident Investigation 10/7/00 10:10	
Division of the or attending P as a first death. In a librator: Affert led in by the funers Certification:	3 XXX uicide 4 ☐ Homicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) found: residence	28f. Location (Street end Number or Rure) Route Number. City or Town, State), 10111-B, ClemsonVille Road Union Bridge, Maryland
DIVISIC To the Hospital or Attend within 24 hours after deet To the Funeral Director: completely filled in by the Medical Certificat	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, da 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion end menner steted.	te end plece, end due to the ceuse(s) end menner es stated.
vithin of the comple	29b. Signature and title of certifier 29c. License num	iber 29d. Date signed (Month, Day, Year)
• • • • •) / M.A. O.C.M.	E. October 08, 2000
	30. Neme and address of person who completed sause of deeth (Item 23a) (Type, Print) MARY G. RIPPLE, M.P. 111 Penn Street	+ Pall-in-na Nr. 1 - 3 01001
State	31. Date filed (Month, Dey, Year) 32. Registrer's Signature	et, Baltimore, Maryland 21201
Registrar	OCT 11 2000 Beneva & Sparker	



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State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** 26.2000 4:05 AM Sept. LEWIS WANDA /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Wicomico Salisbury , Md Salisbury Center; Genesis ElderCare if Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1□M 2XF Months Deys Hours Min Yrs. JAN. 10, 75 1925 DELÁWARE 215-16-3964 **Director** Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow 27 is marked other than "natural", or items 23s or 28s-f shor traumatic event, the Medical Exemples must be notified as 1 ☐ Yes 2 1 No Directo SALISBURY MARYLAND WICOMICO 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Peges 1 end 2 should be lited within 72 hours after death v Department of Health end Mental Hygiene.

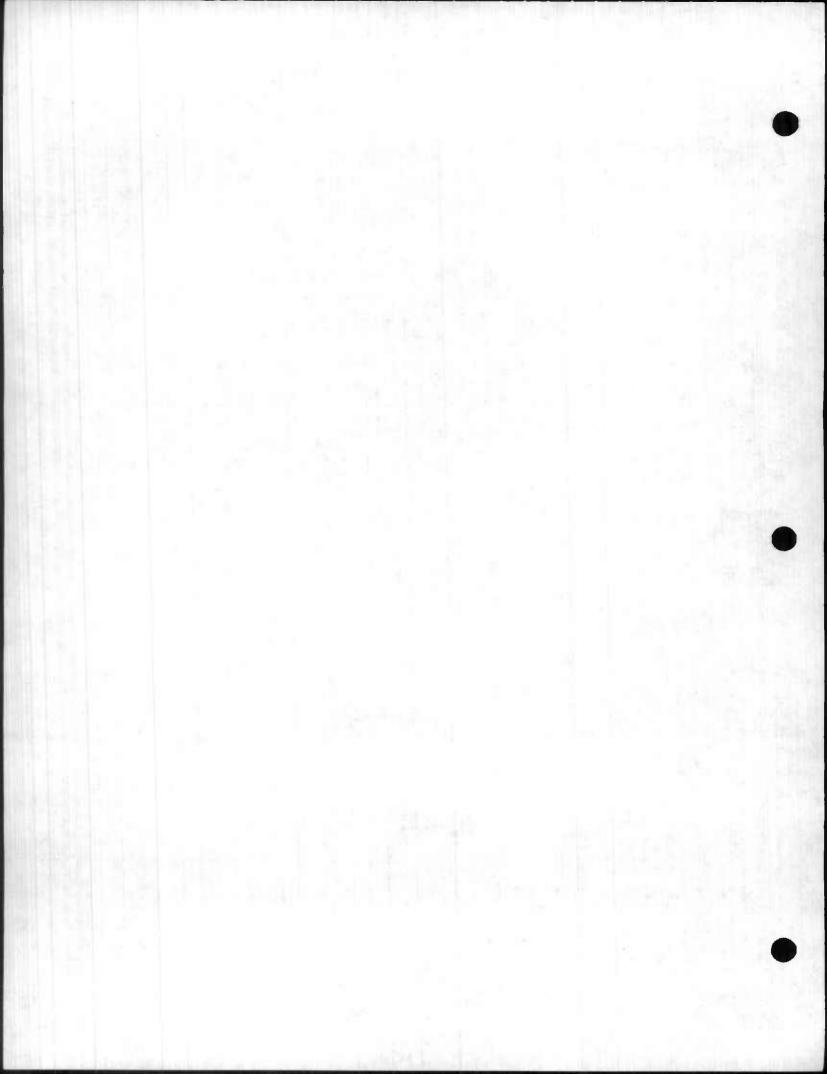
Important: if Itam 27 is marked other than "natural" and virtural or other traumatic events. 6112 STEVE STREET 21804 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 N Married PRAG LEWIS Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: by WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) PHARMACEUTICAL TECHNICIAN 12 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Be UNKNOWN UNKNOWN 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) LLOYD W. LEWIS/HUSBAND 6112 STEVE STREET, SALISBURY, MARYLAND 21804 WANDA P 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) NEW HOPE CEMETERY 9/29/00 WILLARDS, MARYLAND 22. Name end Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Pert 1. Enter the disease, or comp-shock, or heert teilure. List only on positions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one caused on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) CIPPLUSES Examiner Due to (or es a consequence of): Physician/Medical Examiner use as the burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Lest and Due to (or es e consequence of): Box 68760, Due to (or es e consequence of) P.O. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? be deteched 1 Yes 2 No 3 Probably 4 Unknown signed by þ Records, 24b. Were eutopsy tindings eveileble prior to completion of cause of deeth? Be Completed 24e. Wes an autopsy performed? After this certificate has page 1 Yes 2 No 1 Yes 2 No of Vital To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Deeth 28a. Dete of tnjury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury et Work? Division Naturel 2 □ Accident 5 Pending investigation s efter death. I Director: Aft 1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours of To the Funeral I 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated.

Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner steted. Medical 29a. Certifier 29b. Signeture and thinks certifier 29d. Date signed (Month, Day, Year) 29c. License number 25 00 D39813 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21804

Registrar

31. Dete filed (MSE Pay2) 8" 2000

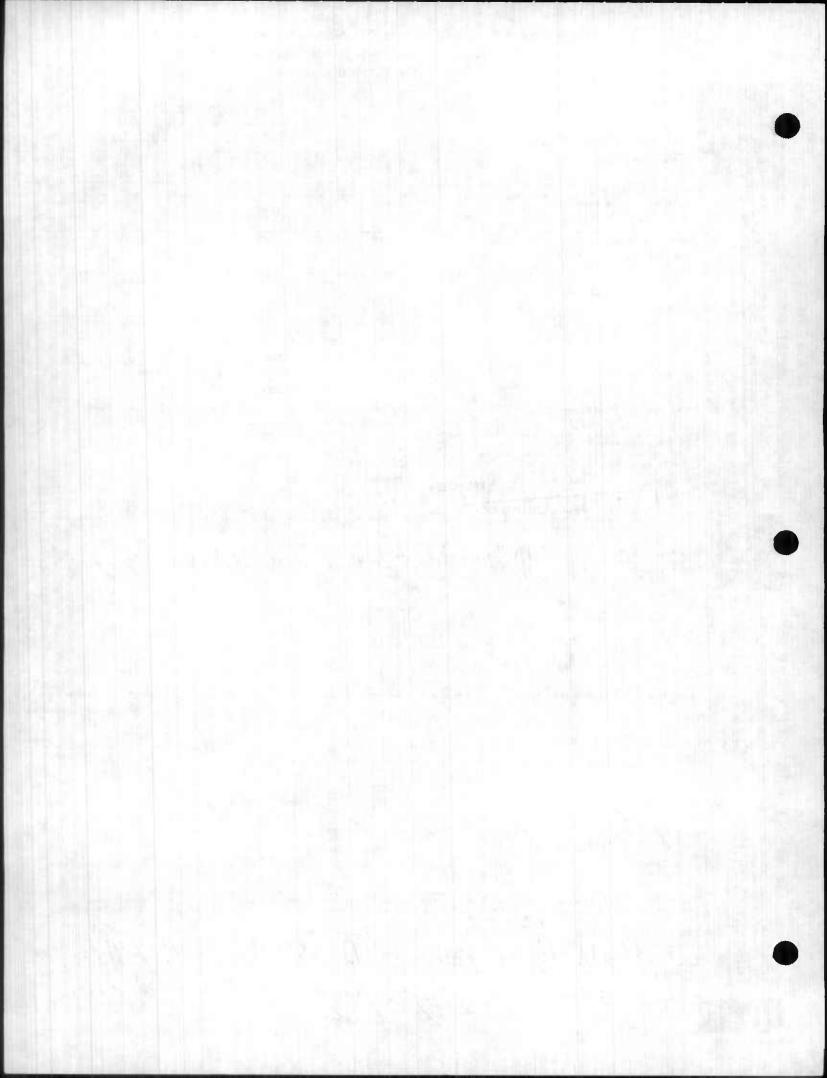
32. Angistrar's Signature



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State of Maryland / Department of Health and Mental Hygiene 00 32273

				Ce	rtificate of	Death		Reg. No.		
	ysician	Decedent's Nama (First, Middle, Last CHARLES ED	st) WIN	LAWHON			2. Date of De Month Septen		3. Time of Death 000 2:45 PM	
	tedical aminer	4a Facility Nama (If not institution, give 28166 PATHFINDER				4b. City, Town, SALISE	or Location of Death	4c. County of WICOM		
Fund Direct		379-20-4000	ex	(In yrs. last birthday 74 Yrs.	Months Deys	If Undar 24 I Hours N	Ain. (Month, Da	y, Year) r 6,1925	9. Birthplace (Stata or Foreign Country) Florida	
Manyland 4 show	led at	Usual Rasidence of Decedant 10e. State 10b. County Maryland Wicomic	30	10c. City, Town or t					10d. Insida City Limits 1 ☐ Yas 2√☐ No	
ar death with the Maryla herre 23a or 28a-f shor	it be notifie	10e. Street and Number 28166 Pathfinder	Court	The state of	10f. Zip Code 218	01		10g. Citizen of Wh	at Country?	
	by Funera	11. Marital Status 1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armad Forcas? 1 X Yas 2 No If Yas, Giva Yaar or Datas:		Was Decedent of H If Yas, specify Cubic 1 ☐ Yas 2 🕱 No	lispanic Origini an, Maxican, Po Specify:	(Specify Yes or No uerto Rican, atc.)		Amaricen Indian, Whita, atc.	
Z1Z15-0020 d within 72 hours at plane r than "natural", or	Completed	15. Decedant's Ed (Specify only highast gra Elementery/Secondery (0-12)	lucation da completed) College (1-4or 5-	(Giv	edent's Usuel Occup a kind of work dona DO NOT usa retired	during most of d)		16b. Kind of Busi		
Maryland 2 d 2 should be fled w th and Mental Hygles 7 te mentaed other ti	To Be Cor	12 17. Father's Nama (First, Middle, Last) Phillip Greene	Lawhon	BOOK	binder Su	18. Mothar's	or Nama <i>(First, Middl</i> a, ene M.	Printing Maiden Sumema) Johnson		
- 594	er traume	19a. Informant's Name/Ralationship (i Alma E. Lawhon/Wi					Rural Route Numb ourt, Sali			
altimore mit. Pages 1:1 partment of He	ury or oth	20a. Mathod of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Other (Specify			osition (Nama of ematory or other place y Cremato		Data 10/2/00		oury, MD	
/Medicate be executed Exami	antificate be executed ing physician and least the burief-trensit as the burief-trensit wedlcal Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only: Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Undartying Cause (Disease or injury that initiated avants resulting in deeth) Last	a. Metas	the death. Do not element of the death of th	equence of):		diac or raspiratory a	^	Approximata Interval Batween Onset and Death White Williams White Williams	
٠ ± ٠ ٤	detached for us	Part II. Other significant conditions of	ontributing to death but	t not rasulting in tha	undarlying ceusa giv	ren in Part I.			ribute to the cause of death?	
The law requires ate hes been sign	2							an autopsy med?	24b. Wara autopsy findings available prior to completion of causa of death?	
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To the Hospital or Atta within 24 hours after de To the Funeral Directo	edical C									
To the To the To the	M W	296. Signature and title of certifier	Grey.	MO	29c. Licans	a number 357	104	29d. Data signed	(Month, Dey, Year)	
x130		30. Name and address of person who	completed causa of da	ath (Item 23a) (Type	Mum (St.	Belin	not	21811	
Do.	State	31. Date filed (Month, Day, Year)	32/Registra	's Signatura	Ano. V	,		1		

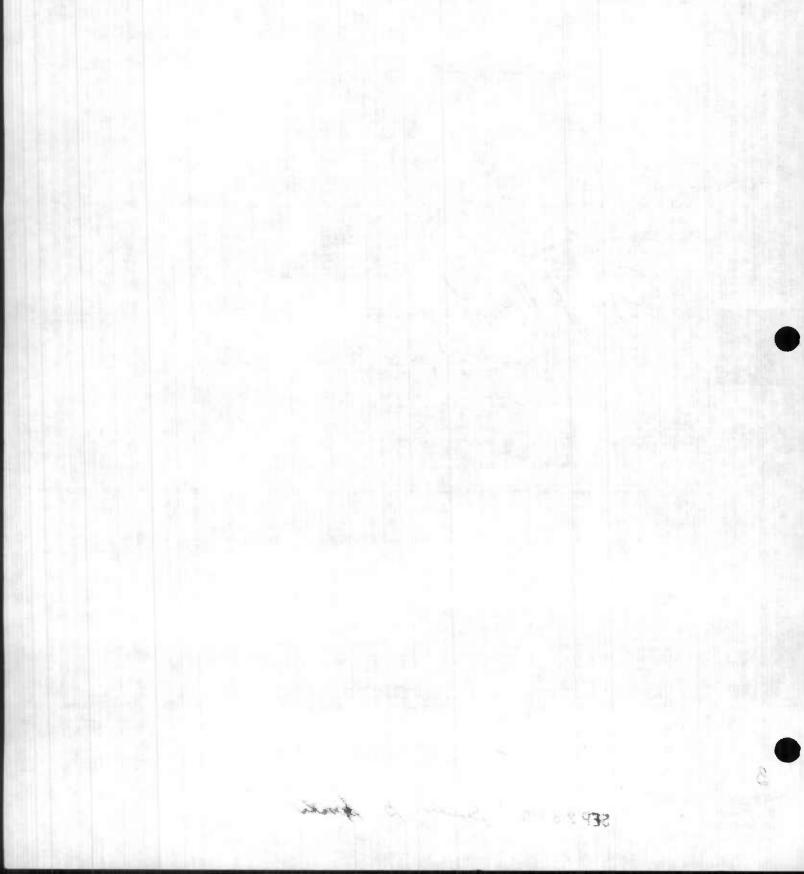


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State of Maryland / Department of Health and Mental Hygiene

ne 00 3227

B					Ce	rtificate of	Death			Reg. No.		has has 1 T
Physician /Medical	1. Decedant's Nama		ast) rank Lar	nb					2. Data of Do Month SEPTEN	Day BER 22,	Year 2000	3. Tima of Death 23:28 PM
Examiner	4a Facility Nama (If ROUTE 3		riva street and nu				4b. City, To White		cation of Daar	th 4c. County CHAR		
Funeral Director	5. Social Security Nu 215-88-4029		Sex 12 M 2□F	7. Aga (In yrs 34	: last birthday) Yrs.	If Under 1 Yaa Months Day	ar If Undar	24 Hrs. Min.	8. Data of Bi (Month, D		9. Birthpi Coun Mary.	iaca (Stata or Foreig try) land
2 *	Usual Rasidence of	10b. County		10c C	ity, Town or Lo	cation				•	11	0d. Inside City Limits
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Oire	10e. Street and Num					10f. Zip Code				10g. Citizan of	What Coun	try?
ath wast		2189 \$	Sidney D				20653			U.S.A.		
	11. Marital Status 1 X Nevar Marris 3 Widowed		Armad Fo	2⊠No va		Was Dacedent of If Yas, specify Cu 1 ☐ Yas 2 ☑ N			cify Yas or N Rican, atc.)	Bia	ce - Amaric ck, Whita, i y: Whit	atc.
2 ho		15. Decedant's	Educetion		16a. Dece	dant's Usual Occ	upation	4 . 6 . 4 . 6		16b. Kind of B	usinass/Inc	Justry
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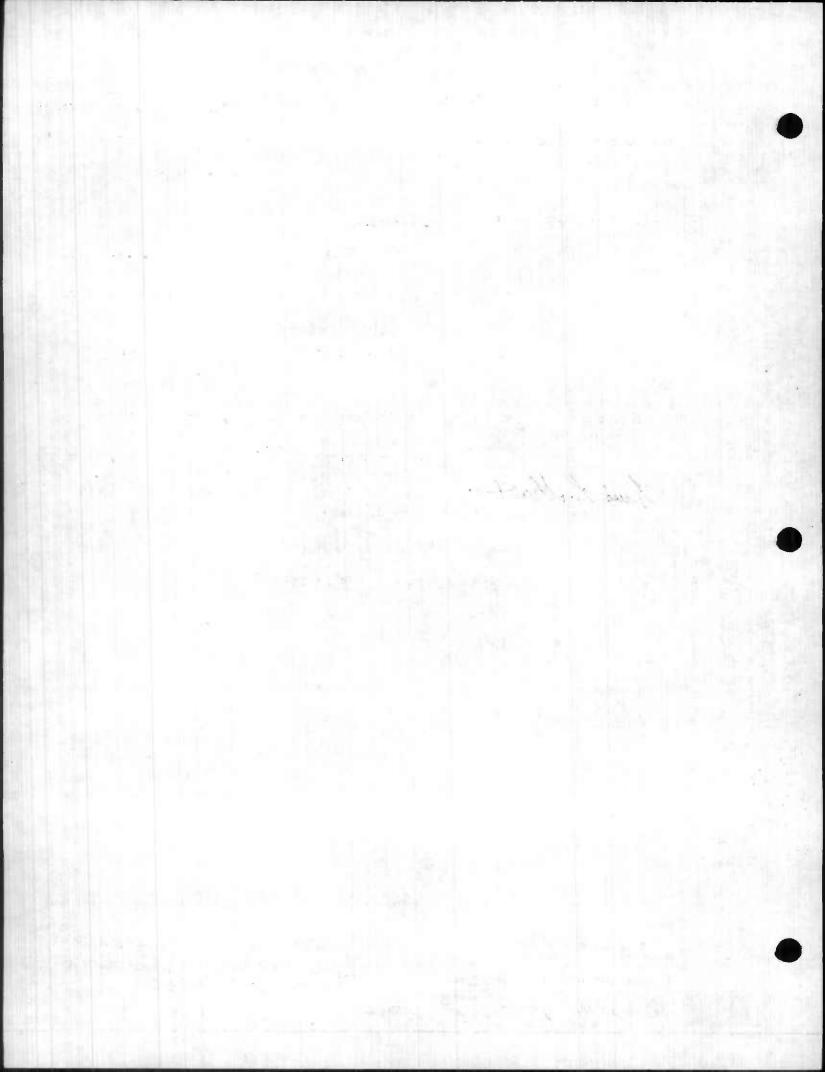


Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death Month 1. Decedent's Neme (First, Middle, Last) Dey **Physician** Robert McNab September 24,2000 12:25 PM /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, giva street end number) 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton 8. Data of Birth (Month, Day, Year) Feb. 24, 1933 Birthplaca (Stete or Foreign Country) If Undar 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Deys Months Hours 10M 20F 578 42 1222 New Jersey Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, Stete r than "natural", or hama 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Prince George's Ft. Washington 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code with 20744 U.S.A. 6801 Janet Lane Funeral 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 11 Marital Status 72 hours after 1 □XYes 2 □ No If Yes, Give 1 ☐ Never Married 2 ☐ Merried 1 Yes 2X No Specify: White Specify: p 3 Widowed 4 Divorced Yaar or Detas: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry oe filed within 7 of Hyglene. I other than "n Elementary/Secondary (0-12) Cotlege (1-4or 5+) Truck Driver Grocerv 12th N/A treumstic event. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17 Father's Nema (First Middle Last) 12 should be fi h and Mentel F 7 le marked of Schwartzman Wallace McNab Norma 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Pnnt) permit. Pages 1 and 2 a Department of Health ar Important: If them 27 le any injury or other treu 6209 Kirby Road Clinton, Maryland 20735 Brenda Lee Shaffer (Daughter) Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removat from Stete Sept. 28, Clinton, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Lee Crematory 22. Nema end Address of Fecility Lee Funeral Home, Inc. 21. Signeture of Funeral Service Licary 6633 Old Alexandria Ferry Road Clinton, MD 20735 aus on brand 23a. Pert1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervet Between Onset end Deeth Physician Immediate Causa (Final disaesa or condition resulting in death) /Medical Examiner Physician/Medical Examiner attending physician and for use as the burial-tran Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Dua to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying causa givan in Pert I. signed by t 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4♥ Unknown Completed by 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was en autopsy After this certificate has N/A 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was casa refarred to medical axaminer? Be 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Natural 2 Accident 1 Yes 2 No or Attend after death Director: 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) filled in by 4 T Homicide To the Heepital or services at the Funeral Di completely filled in Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signature and titla of certifier -a 1/3 9.24.2000 D 24208 30. Name and address of person who completed cause of deeth (Item 23e) (Typa, Print) 8926 Woodycud RId # 10) ABULHASAN U ANSARI Clinty M.D. 20735

Registrar

State

31. Dete filed (Month, Dey, Year) SEP & 6 ZUUU 32. Registrer's Signeture



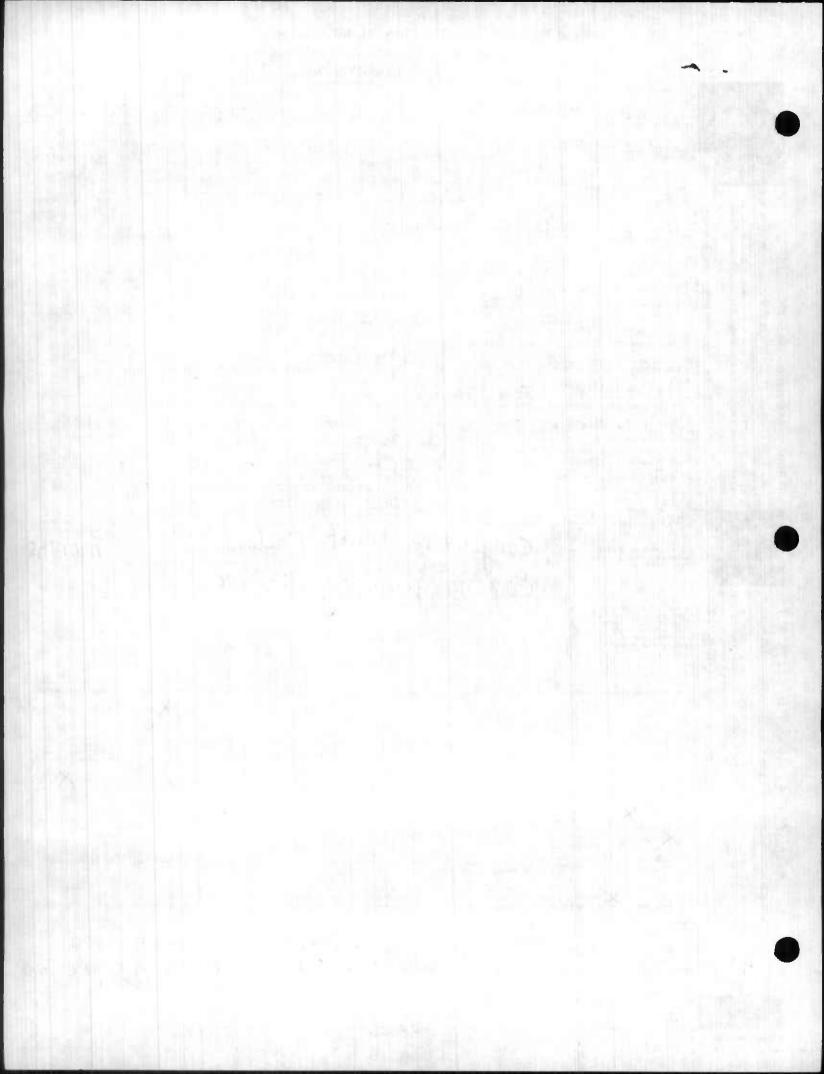
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State of Maryland / Department of Health and Mental Hygiene

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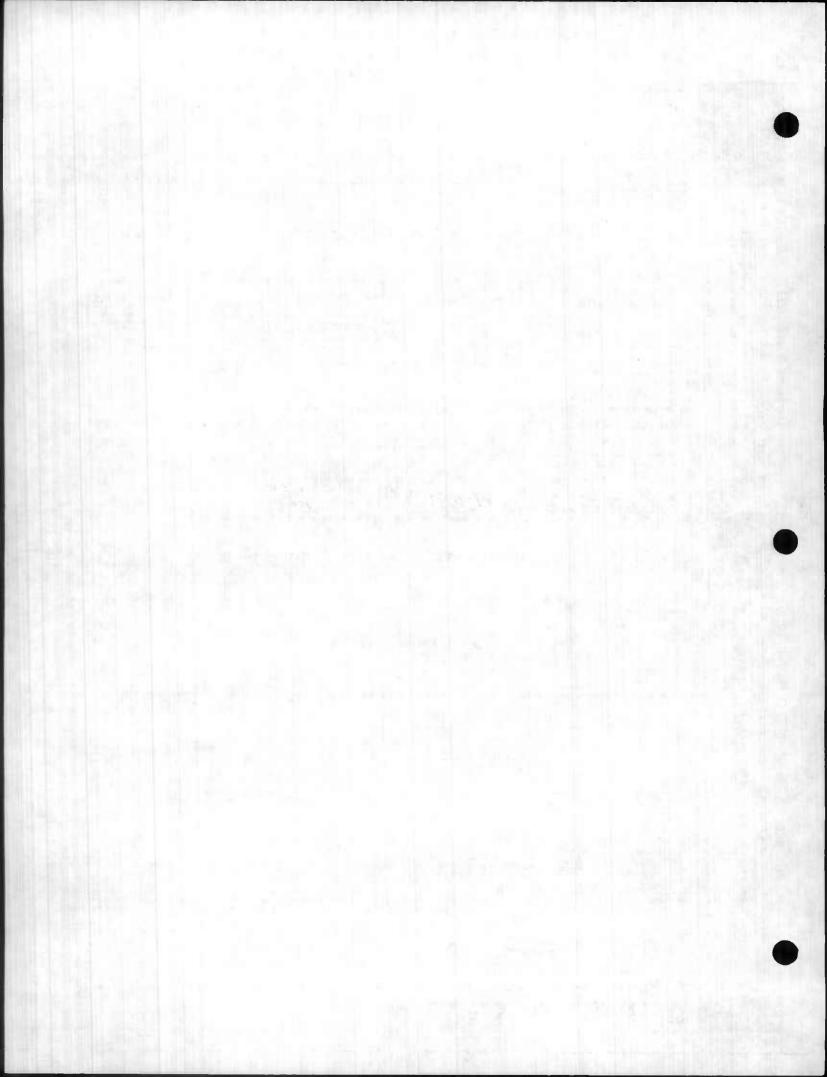


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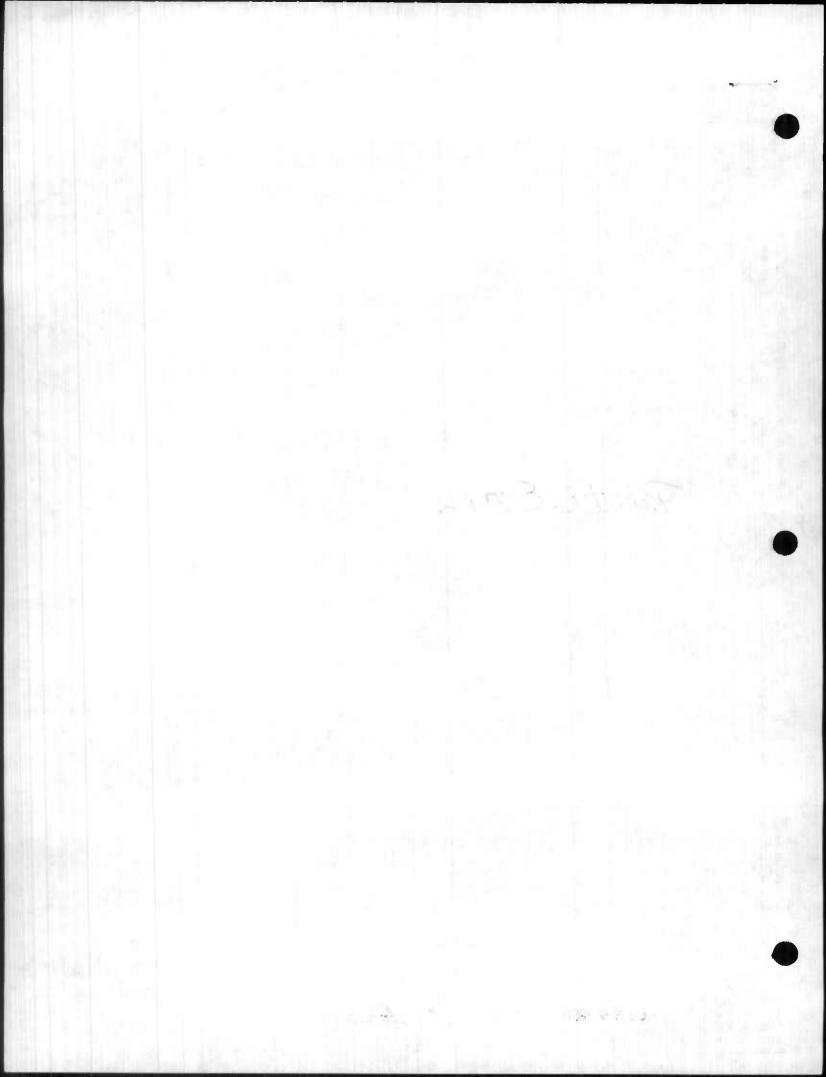
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	30. Nama and address of person who			-							



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State of Maryland / Department of Health and Mental Hygiene 00 32278

		Certificate of	Death	Re	eg. No.							
	Decedent's Nama (First, Middle, Last)			2. Data of Deat Month		3. Time of Death						
Physician /Medical	Thelma L. Martin			Sept.	24 200							
Examiner	4a Facility Nama (If not institution, giva street and number)		4b. City, Town, or Lo	cation of Death	4c. County o	f Death						
	Washington Adventist Hospital		Takoma Pa	rk	Montgo	omery						
Funeral	5. Social Security Number 6. Sax 7. Aga (In yrs. last b	birthday) If Undar 1 Yaar Months Days		8. Data of Birth (Month, Day,	Year	Birthplace (State or Fore Country)						
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within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Cartifier (Check only one) 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.											
Within Somple	29b. Signatura and title of certifier 29c. Licansa number 29d. Data signad (Month, Day, Year)											
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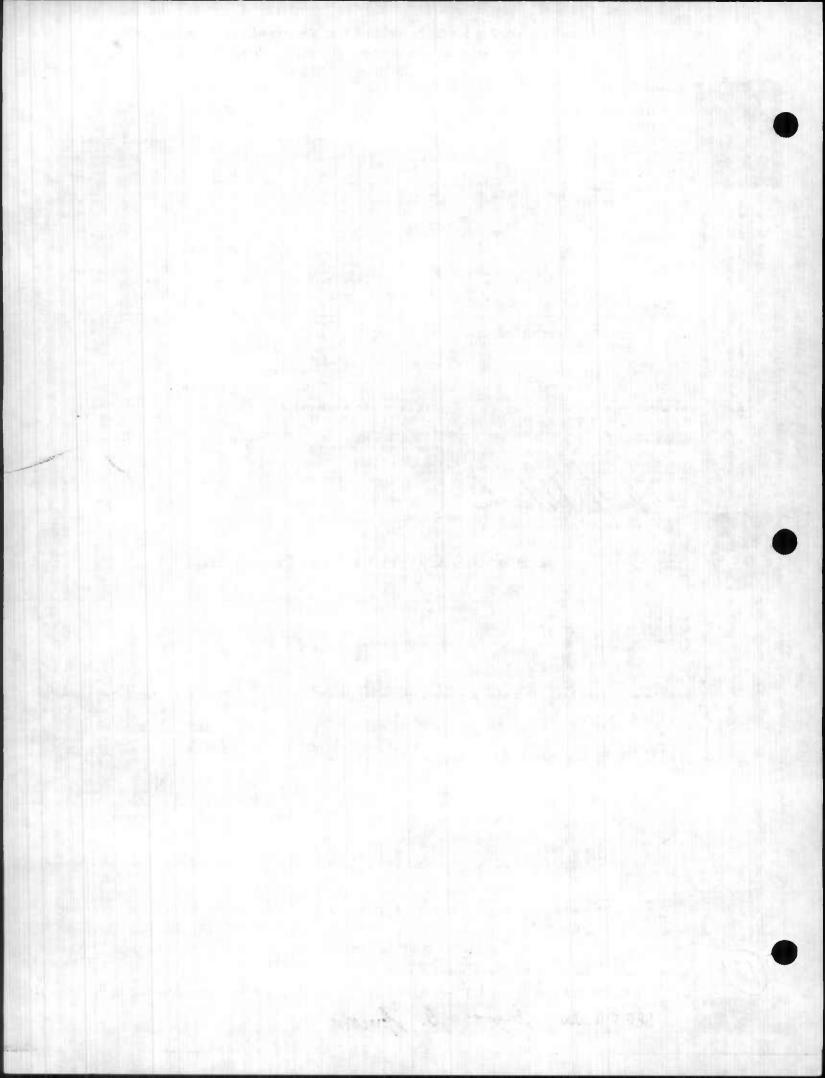
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Funeral Director	5. Social Security Number 077-09-3188	6. Ser	M 2/F	7. Age (In yrs. 90	. last birthd	Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Oct 27	y, Year)	9. Birthp Coun New	plece (Stete or For htry) York	reign
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RUTH CATHERINE

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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Made allering may					viaryian		ificate of	Death		Reg. No.	322	089
Physici /Medi	_	1. Decedent's Name Gladys		Allister					2. Date of De Month		rear	o of Death
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		18606		tance	Cox	ert	-	Accok		Prince		-
Funeral Director		5. Social Security No.	27	Sex 1 □ M 2 🖾 F	Age (In yrs.		Months Days	Hours Min.	8. Date of Birt (Month, Da 2/4/24		9. Birthplece (Sta Country) illiton,	
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3 2 2	by Funeral Director		ed 2 Married	Armed Force 1 Yes 2] If Yes, Giva Year or Date	s? Q No	H,	Yes, specify Cub	an, Mexican, Puer	o Rican, atc.)	Black	White, atc. Black	
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Baitime permit. Peg Department important: I any injury o		21. Signature of Fur			Re		ion Cem		9/21/00	Clinton	n, MD	
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Physician /Medical Examiner	1er	23a. Part1. Enter th shock, or hear tmmediate Cause (I disease or condition resulting in death)	Finat		erios		toe Ca	udio va			Onset a	Batween and Death
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death certi	SC	Part II. Other signifi	cant conditions	contributing to death	but not ras	sulting in the unc	deriving cause of	ven in Part I.	23b. Did	tobacco use cont	ribute to the cau	use of death?
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ng Phys	2	1-Yes 2-7 27. Manner of Death 1-Natural 2-Accident		28a. Data of I (Month,		28b. Tima of Injury	28c. Inju	her: 4 Nursing hery et ork? Yas 2 No	-	dence 6 DOther		
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(5)		30. Name and addre	es of person who	completed cause of	f death (Iter	n 23a) (Type, P	rint)			,	19, 3	
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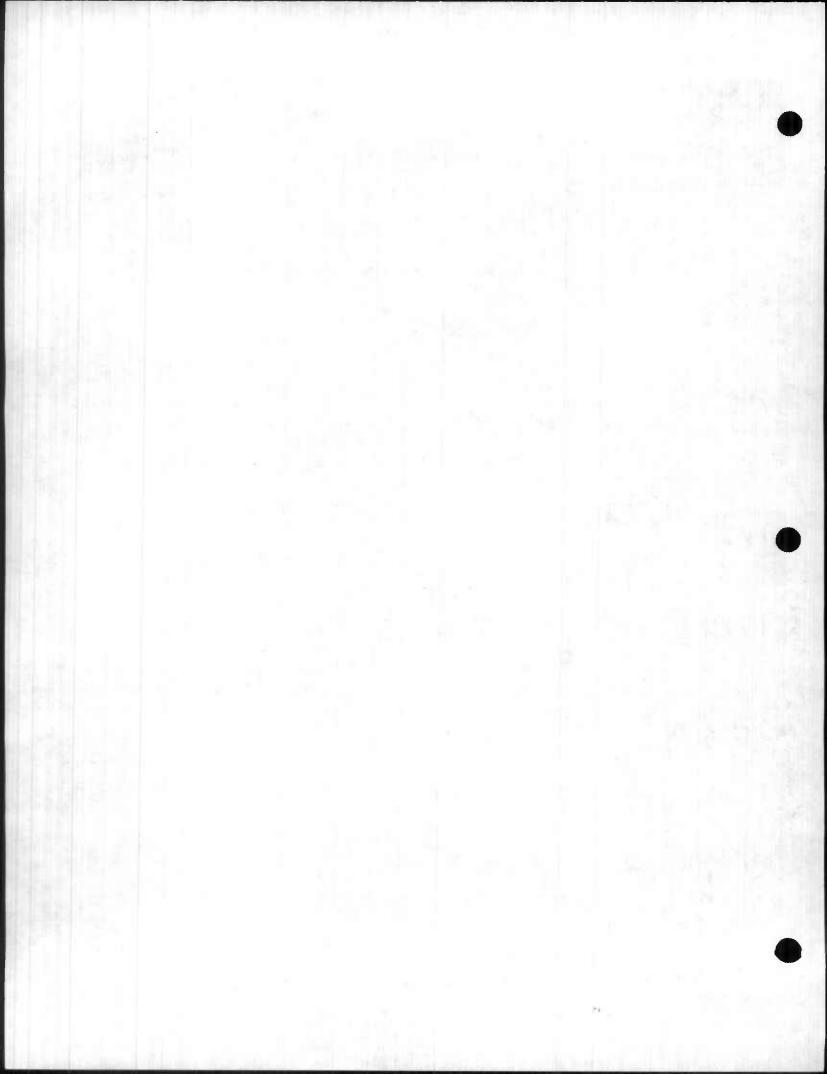
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State of Maryland / Department of Health and Mental Hygiene

						C	Certifica	ate of	Death			Reg. No.				
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	Funeral Director			Sax 1□M 27②F	7. Age (In yrs	. last birtho	Month	der 1 Yaar S Deys	If Under Hours	24 Hrs. Min.	8. Dete of Bi (Month, D	rth ey, Year) - 1942	9. Birthi	place (Stete or Foreign		
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	£ 8 5	Directo	10e. Street and Number				10f. 2	Zip Code			10.74	10g. Citizen				
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020	ors o	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married \$\(\) \	Armed F	XXNo ive	U,S.	If Yes, s	cedent of F pecify Cub 2 X No	an, Mexica	n, Puerto	pecify Yes or N p Rican, atc.)		Black, White,			
Ö	2 ho	te d	15. Decedent's E	ducation		16a. D	ecedent's U	sual Occup	pation	of wor	kin a	16b. Kind o	Business/In	ndustry		
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Maryjand 21215-0020	d out	To Be	17. Fether's Neme (First, Middle, Last Lomax B. Rhode				18. Mother's Name (First, Middle, Maiden Sumema) Helen Sprague						nema)			
2	should nd Men marke		19e. Informant's Neme/Retetionship	Type, Print)		19b. N	Aailing Addre	ess (Street			ural Route Number, City or Town, State, Zip Code)					
	C 0 m m	8	Robert W. Gilr		n						Valdor					
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	within 2 To the comple	¥	29b. Signature and title of certifier	1/	2			29c. Lican	sa number			29d. Date si	gned (Month	, Dey, Year)		
	- > F 0) tankov D-00025						295		Sept	ember 2	29, 2000				
			30. Neme and address of person who					DO	D .	100	T Total	3.00	20011			
			Daniel M. Howell, M		5 E. Char		reet	P.0.	Box 1	1488	LaPlat	a, MD	20646			
	Stat	_	31. Dete filed (Month, Day, Year)		Registrar's Sig	nature	4	6		,						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item #26 as per Physician 10/10/00 cch entificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dey **Physician** 29,2000 September 9:25 pm Henry Monk Jr. · /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Elder Care If Under 1 Year | If Under 24 Hrs. Charles 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 XM 2 F Yrs. 67 Director 247-46-1933 July 7,1933 South Carolina Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examinar must be notified at 1 Nes 2 No Directo Maryland Charles LaPlata 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20646 U.S.A. Funeral 5795 Bumpy Oak Rd 12. Was Decedent Ever in U,S. Armed Forces?

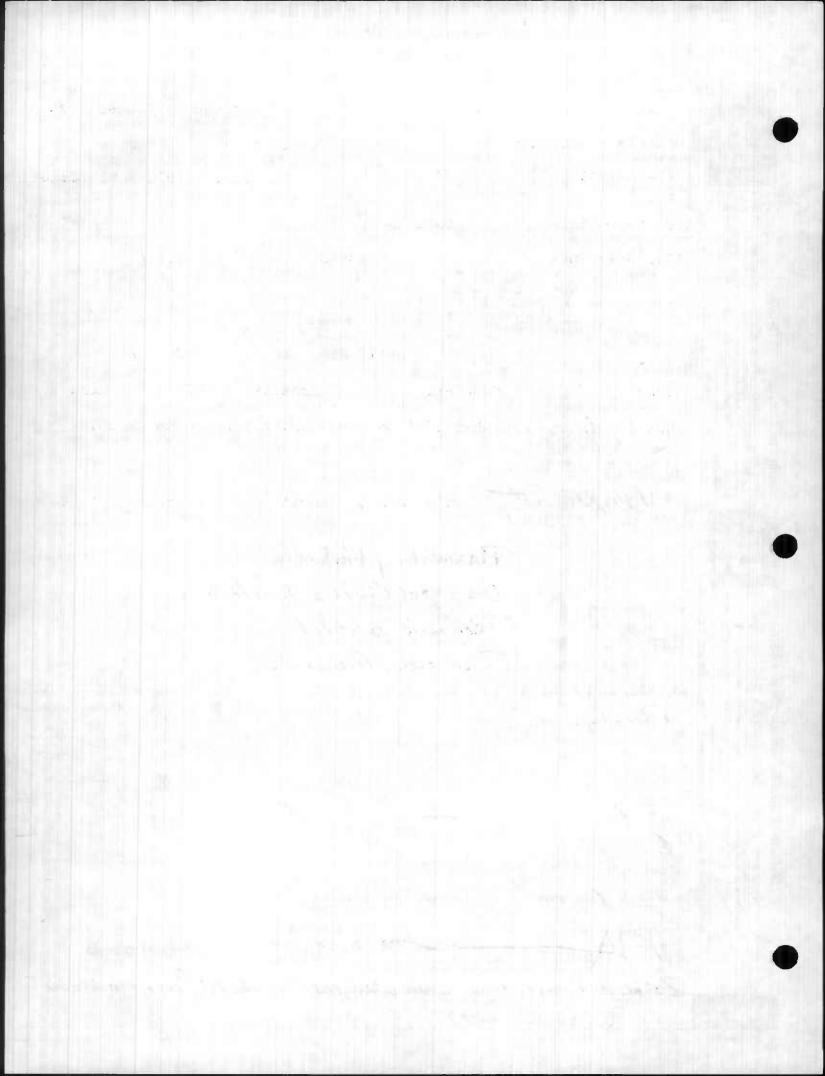
1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 2 should be filed within 72 hours after end Mental Hygiane. Is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Carpenter 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Monk 1º Monk Sr. Ardelia Nivens Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health end Important: If Nem 27 is m any Injury or other traun DAGS. Janet Pugh/Step- Daughter 3200 Dalewood Rd, Ft. Washington MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smith Chapel Cemetery 10/5/00 La Plata, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licanses Adams Funeral Home P.A.Aquasco MD 20608 M191 23e. Part1. Enter my disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one causeion each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting In death) Kespirature Examiner Due to (or as a consequence of) Examiner RYNGEZ/ (PICER attending physician and for use as the bunel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): BILATERE NEUMONIZ Physician/Medical Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. be datached Division of Vital Records, P.O. 3 Probably 4 Unknown 1 ☐ Yss 2 ☐ No 1-ARAphy12 by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? has 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 FROutpatient 3 DOA After this uneral 27. Manner of Death 1 ☑ Natural 2 ☐ Accident 28b. Time of 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: al or Attending F s after death. Il Director: After 5 Pending Investigation 1 Tyes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) à 4 Homicide To the Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end menner as stated. Medicai 29e. Certifier (Check only one) 2 Medical Examiner: On the besis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D0053219 10-2.2000 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

32. Registrar's Signature

Woodyned Rd surte 101 (Intro), MB 20135

State Registrar ZATHE A. H.
31. Date filed (Month, Day, Year)

OCT 03 2000



Registrar

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State of Maryland / Department of Health and Mental Hygiene 00 32284

			C	ertifica	te of	Death		F	leg. No.		- treat be	- 0 ,
	1. Decedent's Name (First, Middle, Las	st)	THE STATE OF			-	2	. Data of Dea		Vana	3. Tima	of Death
Physician	Daniel Joseph Mul	aucon TTT					5	SOTEM 6	Er 28	2000	17	15
/Medical	4a Facility Name (If not institution, give				T	4b. City, To		tion of Death	4c. Count	200		
Examiner	Union Hospital	,				lktor			Cec			
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Director	202-18-1180	14	113				P	ity 22	, 1920	renna	gevan	ши
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eith the Marylar a or 28e-f show be notified at Director	10e. Street and Number			10f. Z	ip Code				l0g. Citizen of	What Cour	itry?	
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To To	Daniel Joseph Mul	lqueen, Ir	•			Made	eline	Elizat	eth Sci	natz		
aho m m	19a. tntorment's Name/Relationship (7	Type, Print)	19b. M	ailing Addre	ss (Street	and Numb	er or Rural i	Route Numbe	r, City or Town	, State, Zip	Code)	
277	Michael Daniel Mu	ilgueen	53	Conco.	rd Ro	1. #27	7 Ast	on. PA	19014			
The Party of the P	20a. Method of Disposition		20b. Place of Di	sposition (N	ame of			Date	20c. Location	- City or To	wn, State	
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a Physical distriction of the Tr. Tr.	27. Menner of Death	28a. Date of Injur (Month, Day	y 28b. Tim		28c. Inju	ry at	28	d. Describe I	ow injury occu	rred		
iff. Aft	1 Neturel 5 Pending invastigation		roar/ Inju	M		Yes 2	No					
Hospital or Attending 14 hours after death. Puneral Director: After tely filled in by the fune ilical Certification	3 Suicide 6 Could not be determined								Street end Num	ber or Run	al Route Mu	umber,
or line	27. Menner of Death 1 PNeturel 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28b. Time of Injury M 28b. Time of Injury M 28b. Time of Injury M 1 Yes 2 No 28b. Plece of Injury At home, tarm, street, factory, office 28b. Time of Injury At Now? 1 Yes 2 No 28b. Describe how injury occur (Month, Day Year) 28b. Time of Injury At Now? 1 Yes 2 No 28b. Describe how injury occur (Month, Day Year) 28b. Time of Injury At Now? 1 Yes 2 No 28b. Describe how injury occur (Month, Day Year) 28c. Unjury at Yes 2 No 28b. Describe how injury occur (Month, Day Year) 28c. Unjury at Yes 2 No 28c. Unjury at Yes 2 No 28c. Describe how injury occur (Month, Day Year) 28c. Dispury at Yes 2 No 28c. Dispury at Yes 2 No 28c. Dispury at Yes 2 No 28c. Describe how injury occur (Month, Day Year) 28c. Dispury at Yes 2 No 28c											
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended #9,09/27/2000, WCHD, HLC 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Day **Physician** CIU AM Clifton MITCHELL 21--90 UU /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KamparesTum TEC-KamonesTun Brutimoris Wind Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Funeral 10 M 20 F Days Months 212161843 Director 85 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c City Town or Location 10d. Inside City Limits MO 1 XYes 2 No Director DITT MURE Maria Tun-28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 4004 Dorchestor Road herns 23s 21207 U.S.A 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11 Merital Status Bleck, White, etc. 1 Never Merried 2 Merried natural, or 1 Yes 2 No Specify: by by 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Heelin and Mental Hygiens Important: If then 27 is marked other tha any Injury or other traumatic — once. Laborer None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be George Mitchell Blanche Way 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George B. Mitchell (Brother) 4004 Dorchestor Rd. Baltimore, Md. 21207 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method ol Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 26/00 Hebron, Md. 4 ☐ Donetion 5 ☐ Other (Specify) Springhill Mem.Garden 22. Name end Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee 821 West Rd.Salisbury, Md.21801 un 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each process. Approximate Interval Between Onset end Death **Physician** /Medical Immediete Ceuse (Final ATHEROSCEROTIC CANDIOMSCULAR DI disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner AISCIE physician end the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last DEXTERYSION Physician/Medicai Due to (or es a consequence of): 980 jo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably → Onknown signed by 1 þ 24b. Were eutopsy findings eveilable prior to 24a. Wes en eutopsy performed? Completed completion of cause of deeth? 1 Yes S=14 1 Yes ZANo 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) 20 No Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Neturel 1 ☐ Yes 2 ☐ No 124 hours after death. Be Funeral Director: A pletely filled in by the fe deeth. 2 Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Box 68760, P.0. Division of Vital Records, Attending Physician: 6 Hospital

Baltimore, Maryland 21215-0020

To the Hosp within 24 hor To the Fune completely fi

30. Neme and address of person who con

2 7 2000

4 Homicide

(Check only one)

29b. Signature and title of confiller,

31. Dete liled (Month, Day, Year)

SEP

29a. Certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year)

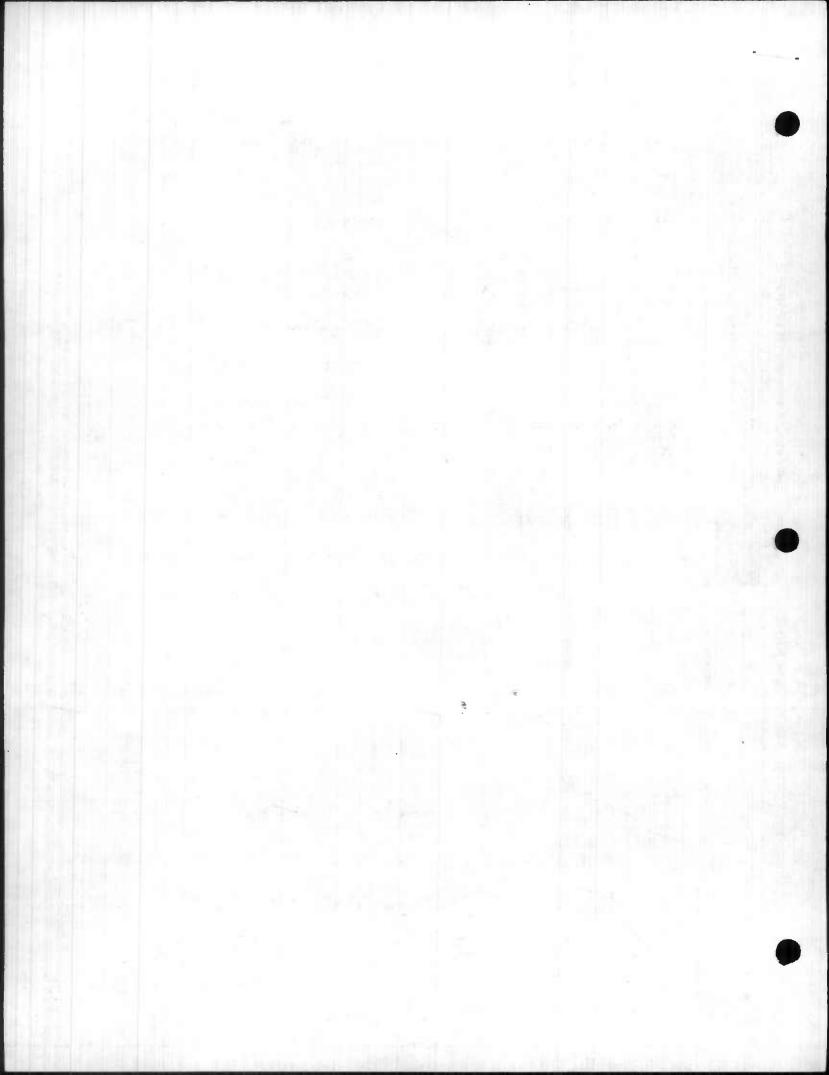
red cause of death (Item 23a) (Type, Print)

34 -115 d

32. Régistrar's Signature

State Registrar

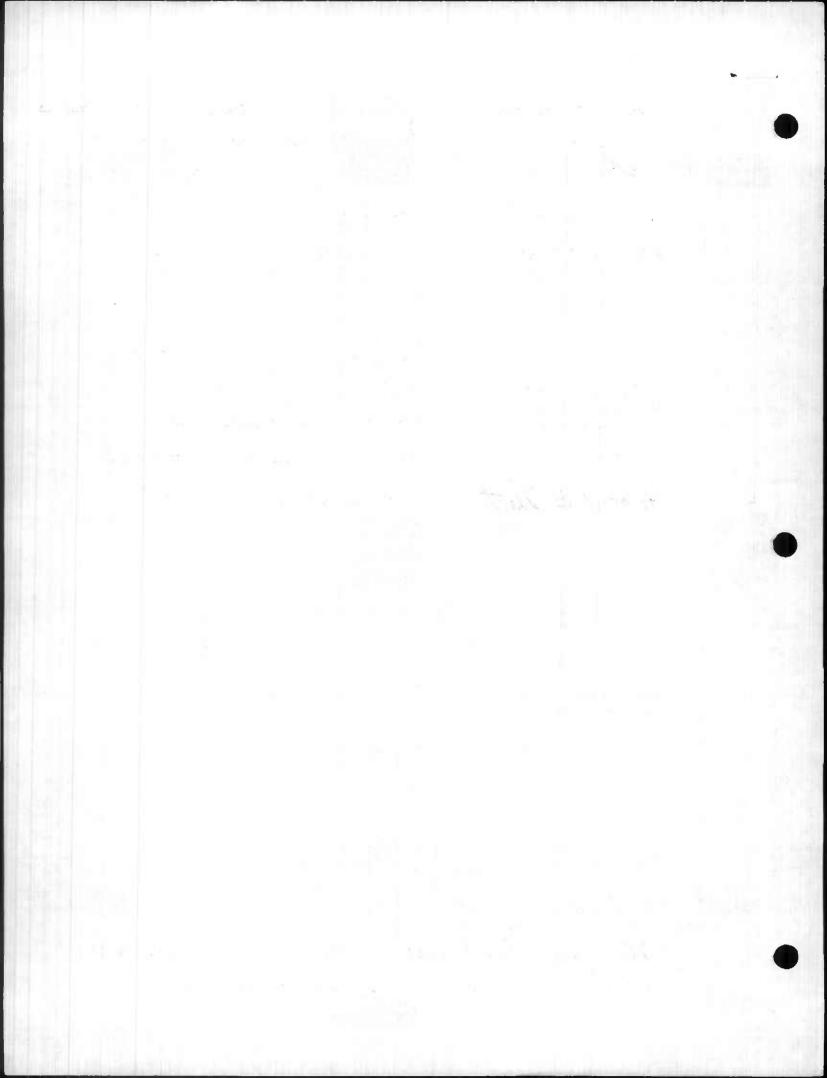
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State of Maryland / Department of Health and Mental Hygiene 00 32286

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Funeral Director		5. Social Sacurity Number 409–20–3792	6. Sa	X 7. A	ge (In yrs. 79	last birthday, Yrs.	If Unda Months			24 Hrs. Min.	8. Data of Bin (Month, Da Aug. 2.	, 1921	9. Birthi Cou NOTW	plece (St ntry) 700d,	ete o <i>r Foreiq</i> Ga.
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To the		29b. Signeture and titla of certifie	r	01	1		29	c. Licer	sa number			29d. Data signe	ed (Month,	Day, Ya	ar)
	-	7/14/07 30. Neme end eddress of person	Moon	of the second	Ru	111	Drips\	DO6	674			Sept.	22, 2	2000	
State		Myron L.Lenkin 31. Dete filed (Month, Day, Year)		D. 2309 S		field		ilv	er Spr	ing,	Md. 209	902			



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Deeth Day Month **Physician** Charles Christopher Nagy SEPTEMBER 22, 2000 9:15 P.M. /Medical 4b. City, Town, or Location of Deeth AAFB 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner CAMP SPRINGS MALCOLM GROW MEDICAL CENTER PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 1956 15€M 2□ F 44 301-56-1848 Yrs Director North Carolina Usuel Residence of Decedent the Maryland 10e State 10c. City, Town or Location 10d. Inside City Limits 10b. County show r than "naturel", or items 23e or 28a-1 shore the Wadical Examiner must be notified at 1 Yes 2 No Virginia Fairfax Springfield Directo 10f. Zip Code 10e. Street end Number 10a. Citizen of Whet Country? 22153-1013 U.S.A. 6976 Conservation Drive Funeral 12. Was Decedent Ever in U,S.
Armed Forcas?

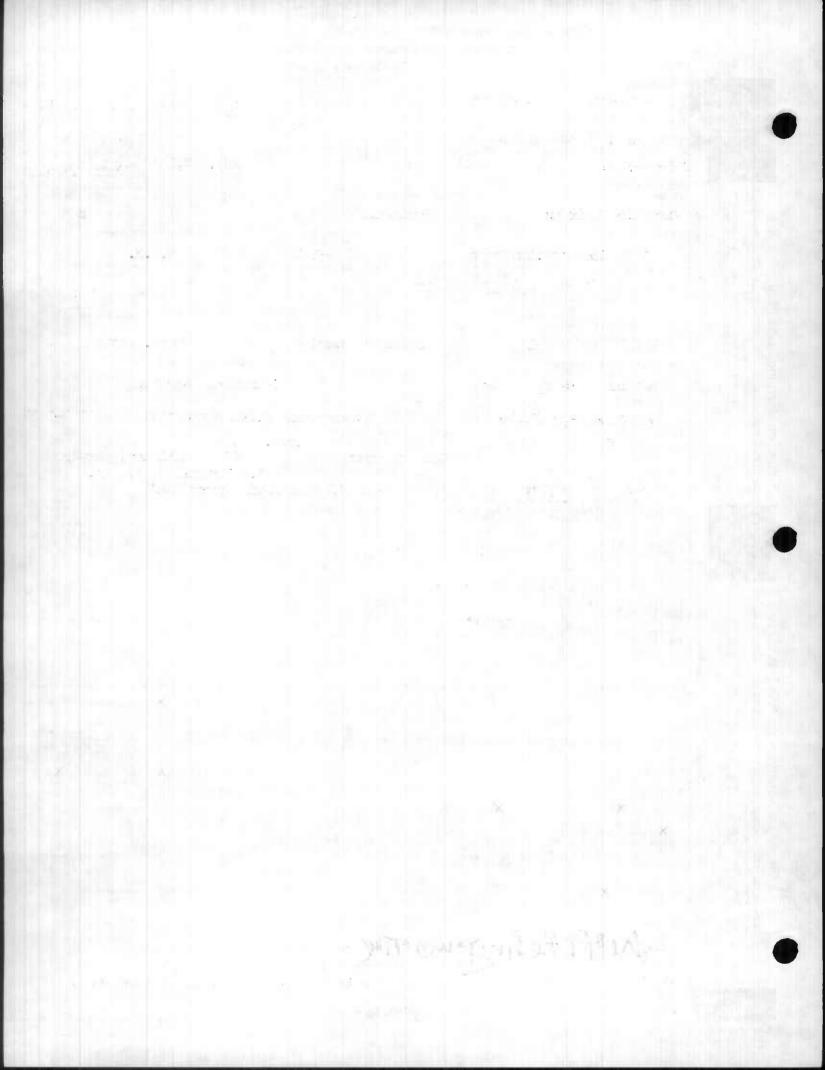
1 ★ Yes 2 → No 1974—
If Yes, Give
Yeer or Dates: 1981 14. Race - American Indian, Bieck, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, atc.) 11 Maritel Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 College (1-4or 5+) al Hygiene. Elementary/Secondary (0-12) Corp. Security Security Guard 18. Mother's Neme (First, Middle, Malden Surnama) 17. Fether's Neme (First, Middle, Lest) h and Mental F Be 90 iit. Pages 1 and 2 should be arment of Health and Menta ortant: If item 27 is marked injury or other traumatic en Terry Catherine Ann Rubin Charles Nagy 19e. Informent's Name/Raiationship (Type, Print) 19b. Mailing Address (Streat end Number or Rurel Route Number, City or Town, Stete, Zip Code) Katherine Nagy (Wife) 6976 Conservation Drive Springfield VA 22153-1013 20e. Method of Disposition 20b. Piace of Disposition (Neme of 20c. Location - City or Town, State cematary, crametory or other place) Sept. 24 1 ☐ Burial 2 Ø Fernation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 2000 Clinton, Maryland Lee Crematory 22. Name end Addrass of Facility Lee Funeral Home, Inc. 21. Signeture of Funeral Service License 6633 Old Alexandria Ferry Road 23e. Pert1. Enter the dileese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervai Between Onset end Death **Physician** /Medical Immediate Ceuse (Finei RESPIRATORY FAILURE UNKNOWN diseese or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner RENAL FAILURE 5 DAYS Sequentielly list conditions, if any, laeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequance of): and physician c. METASTATIC CANCER UNKNOWN Physician/Medical 2 Dua to (or as a consequence of): 8 957 Pert II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown þ 2 24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy performed? Completed completion of ceuse of deeth? 1 ☐ Yes 2 No 1 Yas 2 No 25. Wes cese referred to medicei exeminer? Be 26. Plece of Deeth (Check only one) Hospital: 1 MInpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 28e. Date of Injury (Month, Dey Yeer) 27. Menner of Deeth 28b Time of 28d. Dascribe how Injury occurred 28c. Injury et Work? Certification: 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide to Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piace, and due to tha ceuse(s) and mennar stated. edical 29a. Certifier (Check only one) within 2 To the F 29c. Licansa number 29d. Data signad (Month, Dey, Year) 29b. Signature and titla of certifier PA MD069539L SEPTEMBER 22, 2000 30. Neme and eddress of person who completed cause of ceeth (Item 23e) (Type, Print) 89 MDG/1050 W. PERIMETER RD. SCOTT REHRIG, CAPT, ANDREWS AIR FORCE BASE, MD 20762-6600

State Registrar SEP 2 6 2000

T, USAF, MC AN

32. Registrer's Signature

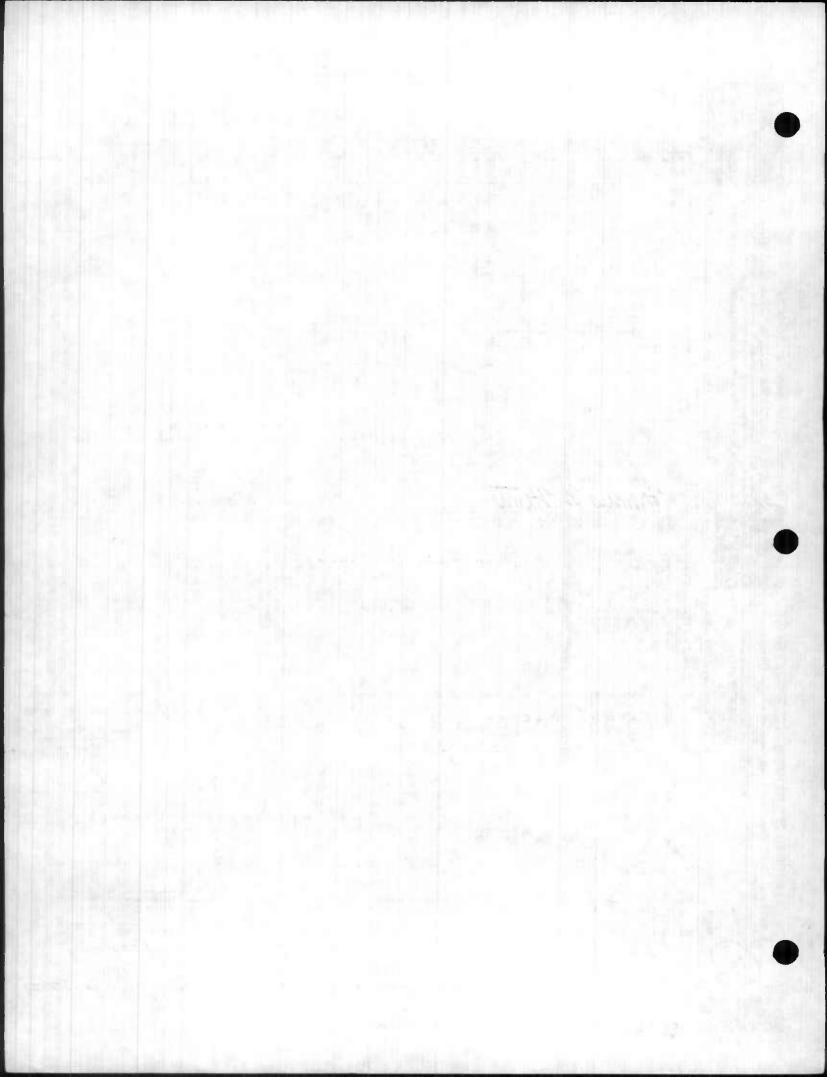


State of Maryland / Department of Health and Mental Hygiene U

Certificate of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death Month **Physician** Mary Ann Neal Sept. 17, 2000 10:20 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, give street end number) **Examiner** ROCKVILLE MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Deys 1□M 2₩F 579-84-2917 41 Wash.D.C Feb.6, Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Germantown Md. OCIYes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Name 23a of 21006 20876 Sojourn Court U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indien. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Giva Yaer or Dates: 11 Never Married 2 ☐ Married 8 Maryland 21215-0020 1 Yes 2√ No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health Care Elementery/Secondary (0-12) College (1-4or 5+) Health Care Marketing Management 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 Roslvn Neal Theresa Turner 19a. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda) 1674 Tamarack St.N.W.Wash.D.C.20012 Ruby Parrish Sherman Friend Health em 27 i Baltimore, 20b. Placa of Disposition (Neme of cematery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 9/25/00 Washington, D.C. Rock Creek Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Hunt Funeral Home 21. Signature of Funeral Service Licensee tramus 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part1. Enter the disease, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical DULMONDRY EMBOLUS Examiner Due to (or es e consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last use as the burial-tran Due to (or es a consequence of): Box 68760, Due to (or as a consequence of): P.O. page 2 should be detached Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CROHNS DISCASE þ of Vital Records, 24b. Wara eutopsy findings available prior to completion of cause of deeth? DERIRECTAL ABSCESS 24a. Was an autopsy Be Completed 2 No 1 Yes 2 No Attending Physician: 25. Was case referred to medicel examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Hopatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division 1 Naturel 2 Accident 5 Pending Investigation death. 1 Yes 2 No after death Director: A d in by the f 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es ateted.

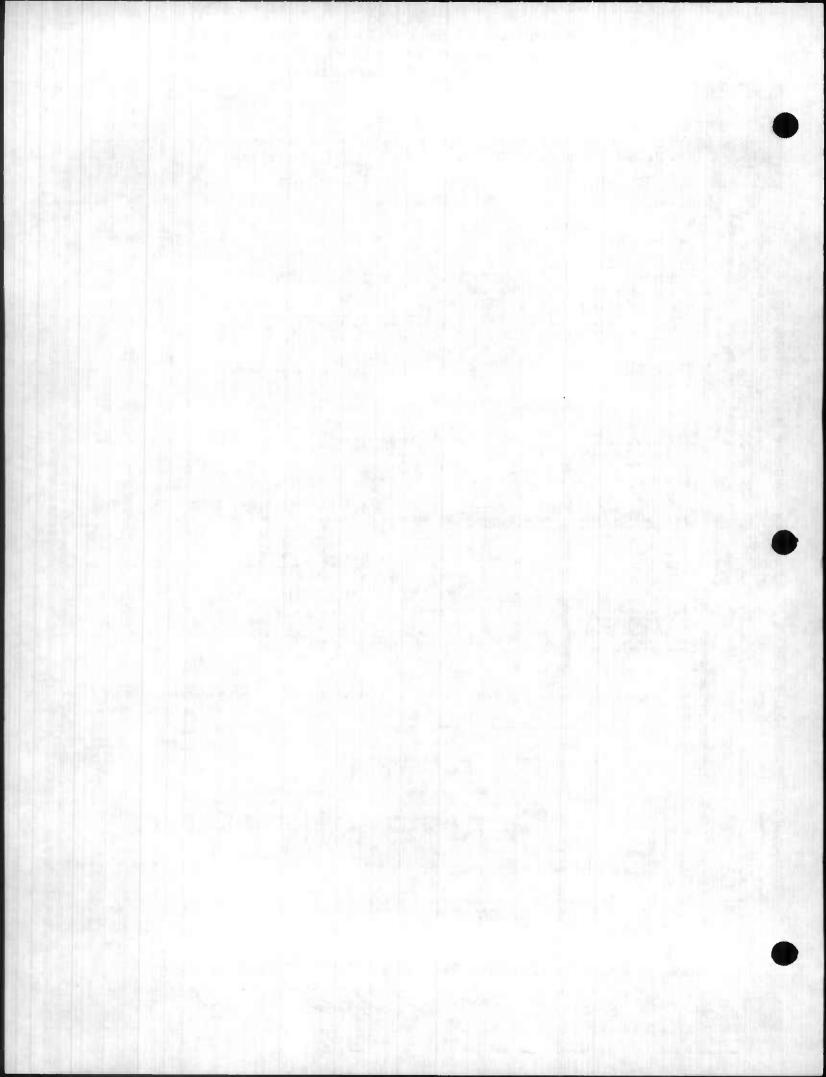
2 Medical Examiner: On the best of axaminetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier (Check only one) 29c. License number 29d. Data signed (Month, Dey, Year) 29b. Signatura and title of cartillar 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 10 for Cockwood Drive; Silver Spring, MD ALAN NAMOND. MD 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State

Registrar



State of Maryland / Department of Health and Mental Hygiene 0 0 32289

									leg. No.		
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Examiner	4e Facility Neme (If not institution, give	street and number)				4b. City, To	wn, or Lo	cation of Death	4c. County	of Deeth	
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Funeral	5. Sociel Security Number 6. Se	ex 7. Age	(In yrs. last b	A	If Under 1 Yea Months Days		24 Hrs. Min.	8. Dete of Birth (Month, Day	Year)	9. Birthplece (Country)	Stete or Fore
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be notified	MD WORCESTI	ER	SHO	OWELL					10- Owl		
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ANTHONY	OWENS

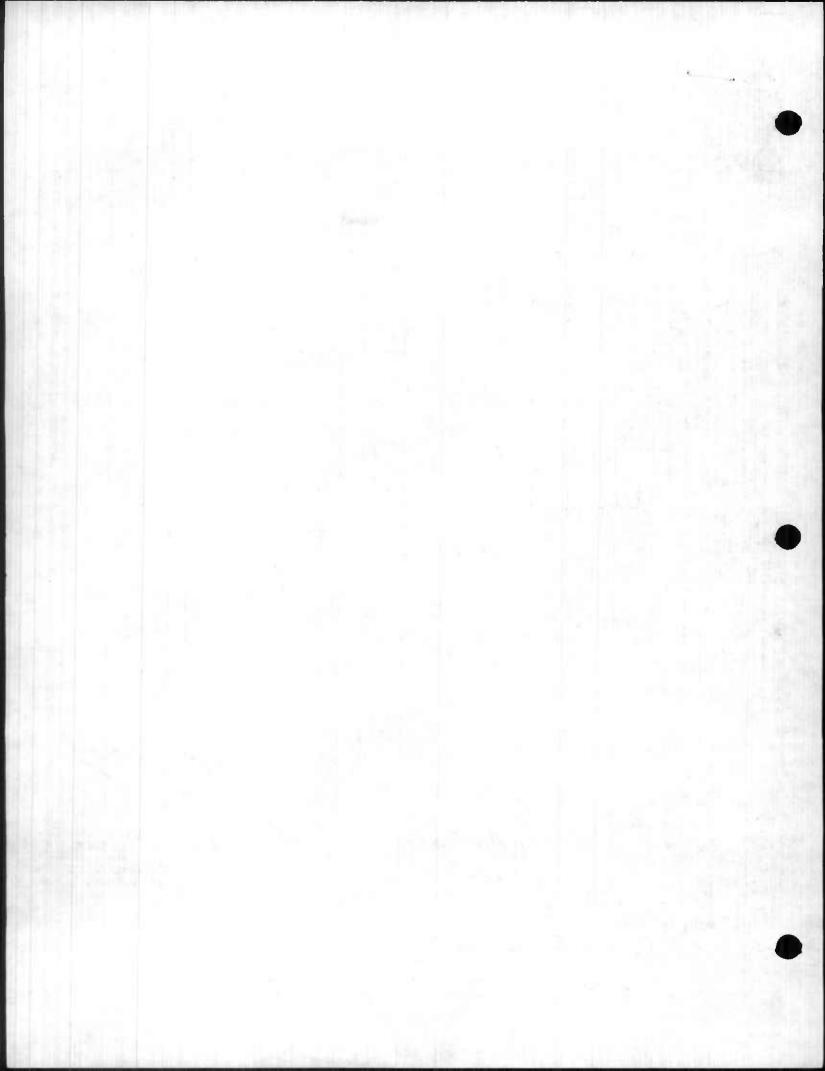
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Dey **Physician** 18, ANTHONY OWENS SEPT. 2000 0147 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Nama (If not institution, give street and number)
PRINCE GEORGES HOSPITAL CENTER Examiner CHEVERLY PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Months Hours XDM 2□F 577-96-7632 June 21,1970 Director Washington, D.C. Usual Rasidence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show 1 Yes 2 □ No must be notified DC. Directo Washington, 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? b flams 23a 918 45th Place, N.E. 20019 United States Funeral 14. Rece - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) filed within 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Carpet Technician Private 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) th and Mental 7 is marked of freumatic eve Pages 1 and 2 should be nent of Health and Mental Jerry Coppock Mary Owens 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2. Department of Health a Important: if New 27 is any injury or other treu Eugenia Denise Owens/ Wife 9401 Silverfox Turn, Clinton, Maryland 20736 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 9/23/00 Landover, Maryland Harmony Memorial Park 22. Neme end Address of Fecility ALEXANDER S.POPE FUNERAL HOMES 2617 Pennsylvania Avenue, SEDC 20020 Pert1. Enter the disease, of beinplications het caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellule. List only one cause on each line. Approximete tnterval Between Onset end Death **Physician** Immedieta Cause (Finet diseasa or condition rasulting In daath) /Medical Examiner Due to (or es a consequance of): Examine The lew requires that the death certificate be executed the bunal-tran Sequentiety list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Diseasa or injury and Due to (or as e consequence of): Box 68760, physician Physician/Medical that initiated evants resulting in death) Lest Due to (or es e consequence of) 80 -SH P.0. 23b. Did tobacco use sontribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were eutopsy findings evailable prior to completion of cause of deeth? Completed 24a. Wes en autopsy performed' page 2 s 1 Yes 1. Yes 2 No 2 No certificate Division of Vital or Attending Physician: director, Be 25. Wes case referred to medicat 26. Plece of Deeth (Check only one) Hospitel: Othar: 4 Nursing Home 1X Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Rasidence 6 ☐ Othar (Specify) this 28d. Describe how injury occurred Pedastroan Somotor Ve 27. Menner of Deeth 28b. Time of Injury Certification: 28c. Injury et Work? : After t struck 1 Natural 5 Pending investigation 9/17/00 2350 M 1 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Vehocle 2 Accident 6 Could not be datarmined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stele) Power 29 5 3 ☐ Suicide 4 Homicide Stree Cheverly Mary (and 1 Cheverly edical 29a. Certifier (Check only one) 2 29b. Signeture and title descrifier 29c. Licensa number 29d. Dete signed (Month, Day, Year) 10 O.C.M.E SEPT. 18, 2000 30. Name was address of person who completed cause of deeth (Item 23e) (Type, Print) Pestaner 111 Penn Street, Baltimore, Maryland 21201 Joseph

State Registrar

SEP 2 6 2000 31 Date

32. Registrer's Signeture



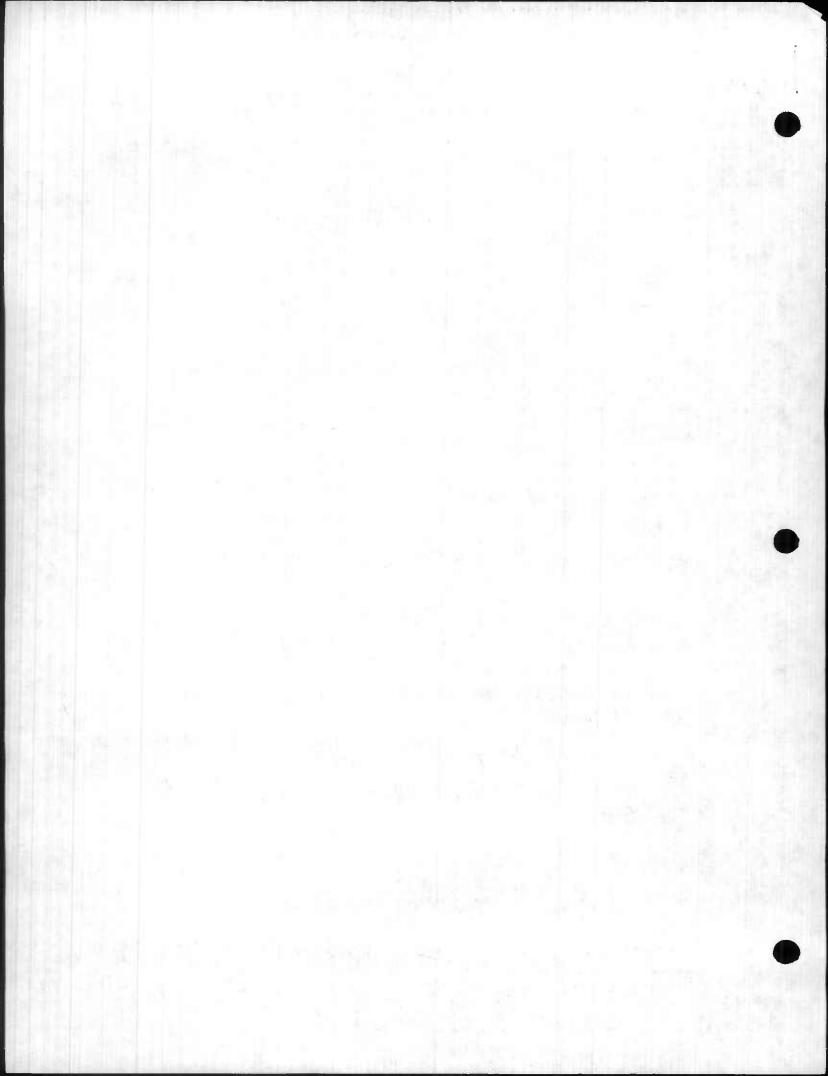
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 205 AM **Physician** =dwarc SEP /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Howard County General Hospital Columbia Howard 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Deys | Hours | Min. 6. Sex 1 → M 2 → F 8. Date of Birth 9. Birthplece (Stete or Foreign Country)
June II, 1933 Massachusettes 5. Sociel Security Number **Funeral** Yrs. 021-24-4173 Director Usuel Residence of Decedent City, Town or Location
Sykesville
SYRESVILLE Peges 1 end 2 should be filed within 72 hours efter death with the Merylend 10a. Stete 10b. County 10d. fnside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Director Howard 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code ò 12643 Howard Lodge Drive 21784 238 USA Funerai 12. Wes Decedent Ever in U,S.
Armed Forces?
1 [2] Yes 2 □ No
If Yes, Give
Yeer or Detes: Korea Neme Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Maryland 21215-0020 "natural", or 1 Yes ZO No Specify. P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Civil Engineer Engineering other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of Edward David O'Connell Marie Beatrice Perron 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth a important: If Item 27 is any injury or other training once. Mrs. Joenne M. O'Connell (Wife) 12643 Howard Lodge Drive Sykesville, MD 21784 Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State All County Cremation Srv. 9/29/00 Sykesville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22, Name and Address of Feculity Haight Funeral Home & Chapel PA (Box 195) 21. Signeture of Funeral Service Licensee Page Haight Herbert Sykesville, MD 21784 (410)-795-1400 23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Interval Between Onset end Deeth **Physician** tmmediete Cause (Finel diseese or condition resulting in death) /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760. Due to (or es e consequence of) P.O. I Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 1 Unknown Division of Vital Records, 24b. Were eutopsy findings evailable prior to completion of ceuse of death? 24a. Wes en autopsy performed? nemic 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Apatient 2 ER/Outpatient 3 DOA nours effer death.

neral Director: After this

filled in by the funerel di After this 27. Menner of Death

1 Accident 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours of To the Funeral (To the Hospital Dertifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner es stated.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Hosp Columbia, MD 21044 ve man 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registra



State of Maryland / Department of Health and Mental Hygiene

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				Certificat	e or i	Death			Reg. No.			
	1. Decedent's Name (First, Middle,	Last)					2. Date of D			3. Time of Deati		
Physician	Troy H.					Month Septem	ber 17,	2000	9:45pm			
/Medical	4e Facility Neme (If not institution,		N LOCAL		4	b. City, To	wn, or L	ocation of Dee		ty of Death	3.43pm	
Examiner	Washington Adve	The state of the s	tal			Take	ma .	Park		gomer	V	
		*	(In yrs. last birti	hdayl If Unde	1 Year	If Under				0	2	
Funeral Director	247-20-551 Usual Residence of Decedant	1∰M 2□ F		Yrs. Months		Hours	Min.	(Month, D	6, 1915	Summ	place (State or Forentry) erton, S	
ž.,	10a. Stete 10b. County		10c. City, Town	or Location						1	Od. Inside City Lim	
tems 23s or 25s-f shorner must be notified at	D.C.		Washi	ington				4.55	10.3		₩ Yes 2□	
the n	10e. Street and Number 333-34th Street	N.E.		10f. Zij	019			10g. Citizen of What Country? United States				
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	11. Meritai Status	13. Was Dece	dent of H	ispanic Orl	gin? (Sp	ecify Yes or N	o- 14. Ra	ce - Americ	an Indian,			
by B	1 Never Married 2 Merrie 3 Widowed 4 Divorced	Armed Forces? d 1 Tes 22 h if Yes, Give Year or Dates:	lo	If Yes, spe		sn, Maxicar Specify:		Rican, etc.)		ack, White, ify: Blac		
ygiena, neturn it, the Medical Completed	15. Decedent's (Specify only highest	Education grade completed)	16a.	Decedent's Usu (Give kind of wo	rk done	durina mos	t of work	ina	16b. Kind of I	Business/Inc	dustry	
mple Men	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT u	se retired	1)	Pipeman Priv			ate		
Co Hara	12			Washing	2011		•					
Be soft	17. Father's Name (First, Middle, L.	ast)						me (First, Middle, Maiden Surneme)				
Menta arised arise ev	Gussie Pearson	LAB THE				Fan	nie	Brunso	n			
alth and 27 is ma ir traum	19a. Informant's Name/Relationship (Type, Print) Doris M. Pearson / Wife 19b. Mailing Address (Street and Number or R. 333-34th Street N.E.										0019	
If Hern othe	20a. Method of Disposition	20c. Location - City or Town, State										
Ty or	1⊠ Burial 2 □ Cremetion 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Telephonetron State Ft. Lincoln Cemetery 9/25/2000Brentwood											
marin a	21. Signature of Funeral Service Li											
O de la company	Kuta.	Jana. His	185	5538	nder Marl	S. F.	ope Pike	e/Fores	1 Homes tville,		20747	
	23a. Part . Enter the disease, or c shock, or heart failure. List o	omplications that caused	the death. Do n	ot enter the mo	de of dyin	ig, such as	cardiac	or respiratory	errest,		Approximate Interval Batween	
hysician Medical	THE PARTY OF THE P	13									Onset and Death	
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Diabetic helpa aid 513										houn-do	
- A			Due to (or as a c	consequanca of)								
nsit		b										
in and fal-transit	Sequentially list conditions,		Due to (or as a c	onsequence of)								
C 79 111	If any, leading to mimediate						i					
buri	cause. Entar Underlying Cause (Disease or Injury	Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of):										
hysicia the bur		C	Due to (or as a co	onsequence of):								
hysicia the bur	resulting in death) Last	d	Due to (or as a co	onsequence of):								
hysicia the bur	resulting in death) Last	d				an in Part I	l.	23b. Did	I tobacco use c	ontribute to	o the cause of de	
hysicia the bur	Part II. Other eignificant condition	d				an in Part 1	ı.		I tobacco use c] Yee 2□ No		1	
gned by the attending physicial be detached for use as the but by Physician/Medical	Part II. Other eignificant condition	d				an in Part I	ı.	10] Yee 2□ No	3 □ Pro	bably 40 Unkr	
gned by the attending physicial be detached for use as the but by Physician/Medical	Part II. Other eignificant condition	d				an in Part t	i.	1 C		3 ☐ Pro	bebly 4 Unkr	
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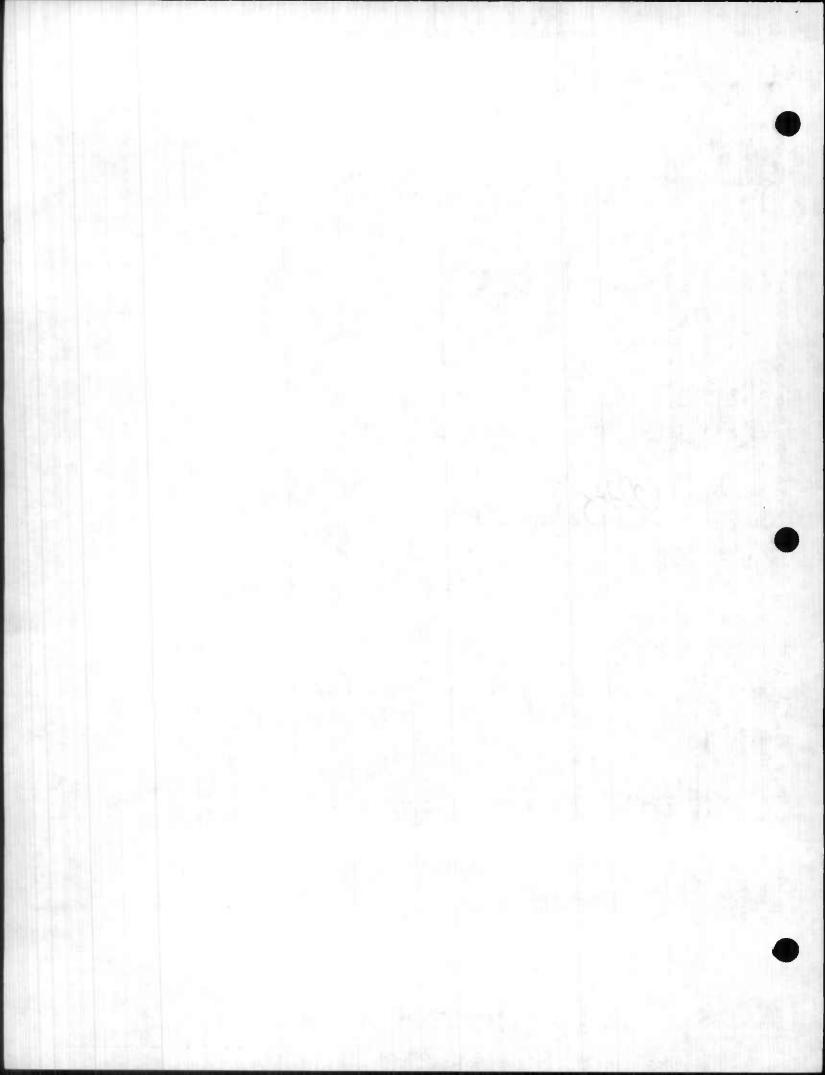
				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Certific	ate of	Death		Reg. No.		and both to	
		1. Decedent's Nema (First, Middla, Las			2. Deta of De Month	eth Day	Yaer	3. Time of Death				
Physici /Medi		Christos C. Poppos	S		4-1				21, 2000		7:15 am	
Exami		4a Facility Name (If not institution, give	a street and number)				4b. City, Town, o	or Location of Deet	h 4c. County	of Death		
		Washington Advent				- to d Vo	Takoma I			gomer		
Funeral Director		5. Social Security Number 6. S 220-28-7438 Usuel Rasidence of Decedent	ex 7. Age ⊠ M 2□ F	(In yrs. last bi	Yrs. If U	nder 1 Yea ths Days			th y, Year) 1933		lece (State or Foreign try) eece	
pus to		10a. Stata 10b. County		10c. City, Tow	n or Location					1	0d. Inside City Limita	
020 urs after death with the Marylar al', or items 23s or 28s-f show	Director	Maryland Prince Go	eorge's	Hyatts		. Zip Code			1√2 Yas 2□N 10g. Citizen of What Country?			
A Po		2111 Guilford Road	d #303			20783			U.S.A.			
death	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was D			(Specify Yes or No erto Rican, etc.)				
15-0020 72 hours after natural, or Ne	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 図 Yes 2 □ No If Yes, Give Year or Dates:3 /	$\frac{1}{23}/5$ $\frac{31}{6}$	/		Specify:	anto Mican, etc.)	Black, White, atc. Specify: White			
re, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. tem 27 is merked other than "natural", or items 23s or 23s-1 show other treumstic event, the Medical Examples must be notified at	Completed by Funeral	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)		f work done OT use ratin	ipation a during most of w ed)	vorking	16b. Kind of B			
be filed w tel Hygier d other ti	3	17. Father's Nema (First, Middle, Last)	2	Se	curity		19 Mothor's N	amo /First Middle		_	ernment	
Maryland 212: d 2 should be filed within th end Mentel Hygiene. 7 is merked other than treumatic event, the M	Be					18. Mother's Name (First, Middle, Maiden Sumeme)						
aryla should nd Men marke	2	Constantinos Pop		198	Mailing Add	iress (Stree	Angeliky Scouperas Street and Number or Rurel Route Number, City or Town, Stete, Zip Coda)					
Mar nd 2 sho lith end 27 is m		Harry Poppos - Bro						lver Spr		209		
Te. 1 er Hea		20e. Method of Disposition	J CHOL	20b. Plece C	f Disposition ry, cremetory	(Neme of		Dete	20c. Location			
Peges ent of nt: # H		1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify				9/27/00	Chelter	ham	MD			
Baltimore, North Peges 1 and Opportunit of Health Important: If them 27 any injury or other unce.		21. Signatura of Funaral Service Licen		IID VC	22. Nam	e and Add	ress of Facility		Onerter	manış	FID	
0 30 E 8 8		102 0 31	1					ome, P.A.				
		23a. Pert1. Enter the disease, or comshock, or heart failure. List only	plications that caused to	he death. Do	not enter tha	mode of dy	e, MD 2	iac or respiratory a	nrrast,	E	Approximata Interval Between	
death certificate be executed we estending physician and ad for use as the burial-transit	Physician/Medical Examiner	disaasa or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· Prie	ua to (or es a	consequence consequence	of):	ALLURE 1 LURE 8D GR	3				
. 0 0 %	sici	Part II. Other significant conditions of	ontributing to death but	not resulting i	n the underly	ing ceuse g	iven in Part I.	23b. Did	tobacco use co	ntributa te	the causa of death?	
P.O. det the detache	Phy							1 🗆	Yes 2 No	3□ Pro	bebly 4 Unknown	
of Vital Records, P.O. Box Physicien: The lew requires that the death cer this certificate has been signed by the eltendin rel director, page 2 should be detached for use	Completed by								performed?		era eutopsy findings ailable prior to implation of causa death?	
I Re lew	E							10	Yes 2 No	1[Yes 2□ No	
f Vital Re yatclen: The la is certificate he director, page	Be	25. Was case referred to medical axaminer?						eath (Check only	ona)			
Of Vita Physicien: this certific	2	1 Yes 2 No	Hospital: 1 S Inpatien			J DOA		Homa 5□ Ras			(y)	
Division of Hospital or Attending Ph 24 hours after deeth. Funerel Director: After the letely filled in by the tuneral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Year)	Time of Injury M		Yes 2 No		how injury occur			
Divi		4 Homicide determined	28e. Place of Injur building, atc.	y - At home, for (Specify)	arm, straet, fa	ctory, office	9		(Street end Numi iwn, Stata)	bar or Hun	al Houte Number,	
Hospital Tale Funeral	edical		ysician: To the best of niner: On the basis of e and menner stets	xamination ar		ation, in my	opinion, daath oc		, date and plece,	and due t	o the cause(s)	
(8)	M	29b. Signature and the of certifier	MD			29c. Licer D4	6529		29d. Data signe	2 E	Day, Year)	
/ VA		30. Nema and addrass of person who VICTOR DNY (SJAKA =	73251	(Type, Print)	POVE	r port	CWAY GI	REAL	LT 1	marilanco	
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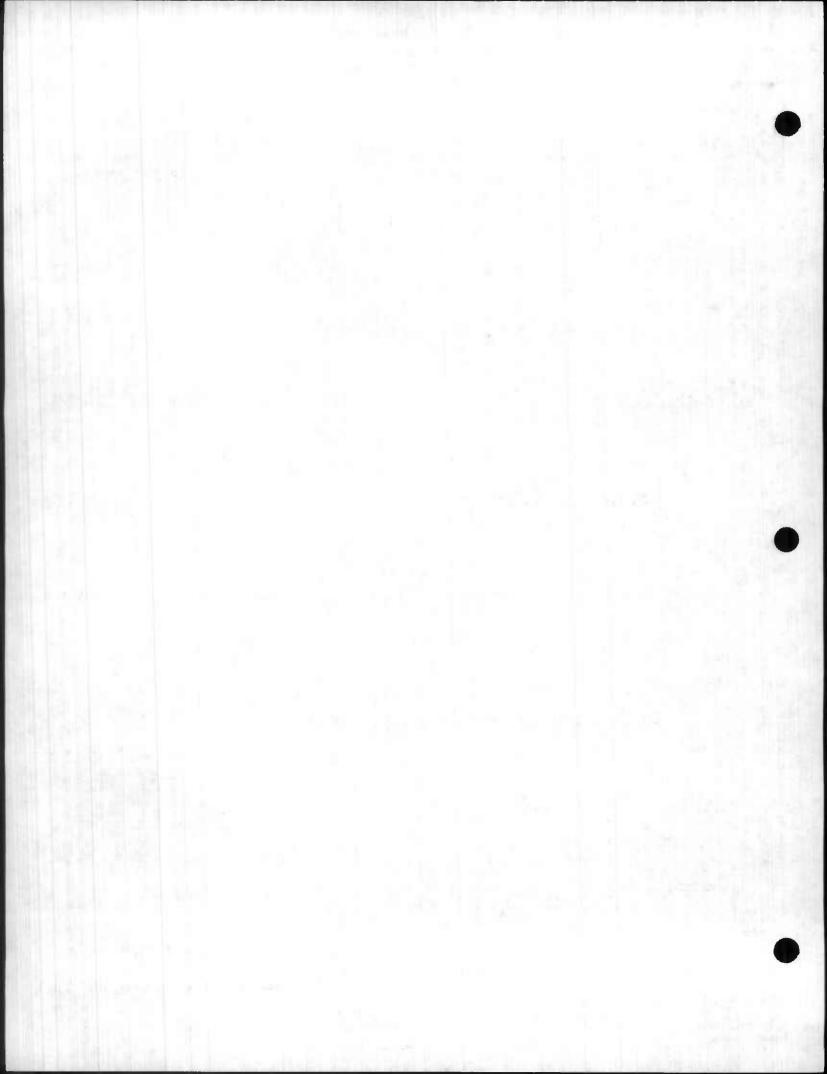
State of Maryland / Department of Health and Mental Hygiene 32294

Physician /Medical Examiner Funeral Director Funeral Director	4a Facility Name (If not institution, give How and Councilland) 5. Social Security Number 219-22-7090 Usual Residence of Decedent 10a. State 10b. County MD. PRINCE G	infred Po re street and number) by genera	L Hosp	intal (City, Town, or Loc	bra	Day 25 2 4c. County o	and			
/Medical Examiner Funeral Director	4a Facility Name (If not institution, give How and Councilland) 5. Social Security Number 219-22-7090 Usual Residence of Decedent 10a. State 10b. County MD. PRINCE G	general 7. Age (In yrs. In	L Hosy last birthday) III	intal (City, Town, or Loc Colcensisted His.	Sept cation of Death	25 2 4c. County o	ood 2:			
Examiner Funeral Director Director	5. Social Security Number 6. S 219-22-7090 Usual Residence of Decedent 10a. State 10b. County MD. PRINCE G	Sex 7. Age (In yrs. In	M	intal (Gleen If Under 24 Hrs.	bra	4c. County o	of Deeth			
be notified at notified at Director	5. Social Security Number 219-22-7090 Usual Residence of Decedent 10a. State 10b. County PRINCE G	Sex 7. Age (In yrs. I	M			9 Date of Birth					
Director	5. Social Security Number 219-22-7090 Usual Residence of Decedent 10a. State 10b. County PRINCE G	Sex 7. Age (In yrs. I	M			9 Date of Birth					
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be notified at Director	Usual Residence of Decedent 10a. State 10b. County MD • PRINCE G			Months Days	Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country) MARYLAND					
in 23a or 23a-1 show it must be notified at neral Director	MD. PRINCE G										
in 23a or 25a-f al ic must be notified neral Director		10c. City	y, Town or Locati	ion				10d. Insida City L 1 ☐ Yes 2			
r must be not ners! Direc		EORGE'S BE	ELTSVII	LE							
r must be	10e. Street and Number			10f. Zip Code			hat Country?				
I I I I	11615 34th PLA	ACE	100	2070	5		USA.				
	11. Merital Status	12. Was Decedent Ever in U.S	S. 13. Was	s Decedent of Hisp	penic Origin? (Spec	cify Yes or No-		- American Indien,			
8 5	1 ☐ Never Married 2 ☑ Merried	Armed Forces?			, Mexicen, Puerto P	(ican, etc.)	- Hilly	c, White, etc.			
Ď Č	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	10	Yes 2 XNo	Specify:		Specity:	WHITE			
a be	15. Decedent's Ed	ducation	16a. Decedent	t's Usual Occupati	ion		16b. Kind of Bus	siness/Industry			
d other than 'n event, the Med Be Comple	(Specify only highest gra	Collega (1-4or 5+)	lifa. DO	NOT use retired)	ring most of workin	g					
	12	4		TEACHE	R	3.46	EDUCA	TION			
	17. Fether's Name (First, Middle, Last))	715		18. Mother's Nama						
To B	JARR	RETT W. SHAUC	CK		ALICE	ARN	OLD				
-	19a. Informant's Name/Relationship (1	Address (Street an	nd Number or Rurel	I Route Numbe	er, City or Town, S	State, Zip Coda)			
at the	EASTON POOL	-HUSBAND	11615	34th PI	LACE, BI	ELTSVI	LLE, MI	D. 20705			
otho	20a. Method of Disposition	20b. Pl	Place of Disposition	on (Name of		Date	20c. Location - C	City or Town, State			
A Of	Maurial 2 ☐ Crametion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	JHemovel from State		MEM . PA		8/00	FIDEDCE	BURG, MD.			
nic .	21. Signature of Emperal Service Lices				of Facility FLE						
D D D	DEN 11/							MD. 2115			
	VIIX										
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	n. Do not enter to	na moda ot dying,	such as cardiac or	respiratory ar	rast,	Approximate Intarval Betwee Onset and Dea			
ician dical	Immediate Cause (Final	0	,	1	- 1			Onot and Boo			
niner	Immediate Cause (Final disease or condition resulting in death)	a. Les	mas a consequer	my Ja	lure			week			
				nagrafi (carci						
sit		o. Metasta	1-c	lung	Cara	non	a	week			
fal-transit Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or	r as e consequer	nce of):							
	ceuse. Enter Underlying Cause (Disease or Injury	C	4								
I physicien end is the burial-transit edical Examir	that initiated events resulting in death) Last	Due to (or	r es e consequen	nce of):							
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letached for us Physician	Part II. Other eignificant conditions of	ontributing to death but not resu	ulting in the unde	orlying cause givan	n in Part I.	23b. Did 1	tobacco uae conf	tribute to the cause of c			
Phy	Acmiration m	neu na na sa	2 Pa	rlein c	Da /	1,20	2□ No	3 Probably 4 Un			
rate has been signed by the page 2 should be detached Completed by Physic	Topic word fr)	, 20, 31	37(3			045 141			
ponion bear	disease 1	De pression				24a. Was perfo	an autopsy med?	24b. Wera autopsy find available prior to completion of cause			
ge 2 sh)	1						of daath?			
Com						101	Yas ZX No	1□ Yes 2D No			
0 0	25. Was case raferred to medicel		W		26. Place of Death	(Check only o	one)				
	examiner?	Hospital: 1 Inpatient 201	ER/Outpatient	3□ DOA Other	r·		dence 6 Othe	or (Specify)			
E = -	27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of	28c. Injury a			how injury occurre				
e funer	Natural 5 Pending 2 Accident investigation		Injury		es 2 No						
Director: After Jin by the fune ertification	3 ☐ Sulcide 6 ☐ Could not b	286. Place of injury - At no	oma, farm, street	, factory, office	2			er or Rurel Route Numbe			
ed in by the funeral Certification:	4 Homicide	building, atc. (Specify	<i>(</i>)			City or Tov	vri, State)				
	29a. Cartifiar Certifying Ph	nyefclan: To the best of my know	wiedge, death or	ccurred at the time	a, data and place a	and due to the	cause(s) and mar	nnar as stated.			
dic dic		niner: On the basis of examinat and menner stated.									
To the Funeral Direct completely filled in by Medical Certifi											
E 2	COU. SIGNIFICATION AND THE CIT CHITINGS	D. FCCP			_		C +	25 2000			
M S	29b, Signature and tree of certifier	1, 1661		112	VIII		24.40				
N Comp	· 4> M	•	1217		36845		Jepi !	25,70000			
Comp		•	1 23a) (Type, Prin		-Chi h	guye	m, 211), FCCP			
no no no no no no no no no no no no no n	· 4> M	•	Cum bor		-Chi h	guy.	m, 211), FCCP			



State of Maryland / Department of Health and Mental Hygiene 00 32295

				Cei	rtificat	e of	Death		P	leg. No.			
	1. Decedent's Neme (First, Middle	e, Last)		DNE	233.7				2. Date of Dea Month	th Day	Year	3. Time of Death	
Physician	Hazel M. Pe	nix							Sept.	27 2	000	2:30 AM	
/Medical Examiner	4a Facility Name (If not institution	, give street end nur	mber)			-	b. City, To	wn, or Lo	ocation of Death	4c. County	of Death		
LAGIIMICI	4650 Roop R	oad					Mt.	Air	Y	Car	roll		
Funeral	5. Social Security Number		7. Age (In yrs. las	st birthday)		1 Year	If Under	24 Hrs.	8. Dete of Birth	1	9. Birthp	laca (State or Foreign	
Funeral Director	293-28-2671	1□M 2対F	76	Yrs.	Months	Days	Hours	Min.	Nov. 9	1923	Coun	laca (State or Foreign try) ntucky	
Director	Usuel Residence of Decedent												
9 Bu	10a. State 10b. County		10c. City,	Town or Lo	ocation		1				1	0d. Inside City Limits	
Age of	Maryland Carr	011	м	t. Ai	rv							1 ☐ Yes 2 No	
or 28a-t 1 be notifie Directo	10e. Street and Number	011			101. Zip	Code				10g. Citizen of W	het Coun	trv?	
1 0 E		,				177							
ath ath	4650 Roop Roa							1 0 10	7 14 1 11	United States fy Yes or No- 14. Raca - American Indie			
) thar death with the Maryla ritems 23e or 25e-f shor sizer must be notified at Furneral Director	11. Marital Status	Armed Fo		13.	Was Deced	dent of H	ispanic Ori an, Mexicai	gin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	Black	k, Whita,		
	1 Never Married 2 Marr	ied 1 ☐ Yes If Yes, Giv		371/2	1 ☐ Yes	28 No	Specify:			Specify:			
21215-0020 d within 72 hours at gene. In the Medical Exam completed by F	3 ☑ Widowed 4 □ Divorced	Year or D									W	hite	
15-0 172 ho natural dical	15. Decedent	t's Education	ted) 18a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)						ing	16b. Kind of Bu	siness/Inc	dustry	
within see. then be like	Elementary/Secondary (0-12)	College (1	1-4or 5+)	life.			1)				0.		
1 2121 ad within ygiene. ner than rt, the Me	8th			Owner							tion/Garage		
ind 2	17. Father's Name (First, Middle,	Last)					18. Moth	er's Nam	e (First, Middle,	Maiden Sumem	9)		
Maryland d 2 should be file in and Mental Hy is marked othe traumatic event	John A. Conl	.ey					На	ttie	Cantre!	11			
T SAME	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address	(Street	end Numb	er or Rur	el Route Numbe	r, City or Town,	Steta, Zip	Code)	
CEN b	W. Gail Kline	daugh	ter	4650	Roop	Ro	ad M	t. A	iry, MD	21771			
o - se med	20a. Method of Disposition		20b. Pla	ca of Dispo	osition (Nar	ne of			Data	20c. Location -	City or To	wn, State	
Baltimore, semil. Pages 1 ar Separament of Hea mportant: If Item my Injury or othe MES.	1 ☑ Buriel 2 ☐ Cremation 3 ☑ Removal from State cemelery, crematory or other place)								/30/200	0 Hano	701	Ohio	
ting the bar	21 Signation of Funeral Service Licensee 22. Name and Address of Facility										ver,	OHIO	
Sall semit my in nort	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Directors, P.A.												
W 202 8 8	Jaemer (2 000	every									MD 21784	
	23a Part Enter the disease, or	complications that c	aused he death.									Approximata Interval Between	
Physician	hock or heart failure. List	Only One cause on e	aci iiya.									Onset and Death	
/Medical	Immediate Causa (Final											1	
Examiner	resulting in death) a. Sowel ischemica week												
Part of	Due to (or es e consequenca of):												
osecuted in and sai-transit Examiner		b. H	odomino		Portic		Huer	Lyve	W			4 year.	
and and si-tra	Sequantially list conditions, if any, leading to immediate causa. Enter Underlying												
X 68760, erificate be executed ling physicien and is as the bunal-transit Medical Examir	Cause (Disease or Injury that initiated events	С											
6876C	resulting in death) Last	1963	Due to (or e	s e consec	quence of):						1		
M se al		d.											
Box seth cert attendin for use													
o. Bc e deeth the atter hed for u	Part II. Other significant condition	ns contributing to de	eath but not result	ing in the u	inderlying o	ause giv	en in Pert	1.	23b. Dld 1	obacco uae cor	ntributa to	the cause of death?	
· = >0 F									10	Yes 2□No	3 Pro	bably 4 Unknown	
E X 0 .	Ecold Stu	ye ne	ual d	isew	0								
Records, P. ne lew requires that shas been signed b sge 2 should be deta		9								an autopsy rmed?		ere autopsy findings eileble prior to	
The lew requirements the lew requirements been signed as should Completed									perio	imeq:	CO	mpletion of cause death?	
The lew ate has b page 2 si									40	res 219 No			
= F # 0									101		11	☐ Yes 2☐ No	
Of VItal I Physician: The rail director, par	25. Was casa raferred to medical examiner?	Hospital:				Ott	26. Plac	e of Deat	th (Check only o	na)			
T digital	1 Yas 2 No	101		R/Outpatie		JA	4 L N	ursing Ho	oma 5 Rasio			(y)	
After funeration:	27. Manner of Death 1 □Natural 5 □ Pendin	28a. Date (Mon	th, Day Year)	28b. Time o		28c. Injui			28d. Describe r	now injury occur	60		
Attending or deeth. ctor: After fune by the fune fune fune fune fune fune fune fun	2 Accident Investig	gation			М	1 🗆	Yes 2	No					
DIVISION Tor Attending after deeth. Director: After d in by the fune ertification	3 ☐ Suicida 6 ☐ Could i 4 ☐ Homicide datarm	ined 200. Place	of Injury - At homing, atc. (Specify)	ne, farm, st	reet, factor	y, office			28f. Location (5 City or Tox		er or Rura	al Route Number,	
DIVISION C bal or Attending P is after deeth. al Director: After t ed in by the funers Certification:			2										
Hospital 24 hours of Funeral I stely filled	29a. Certifiar 1 Certifyin	g Physician: To tha	best of my knowl	edge, deat	h occurred	at tha ti	ma, date a	nd placa,	and due to the	causa(s) and ma	nner as s	tated.	
Div To the Hospital or A within 24 hours after To the Funeral Direc completely filled in b Medical Certif	(Check only 2 Medical one)	Examiner: On the ba	asis of examination ner stated.	n and/or in	vestigation	, in my o	pinion, da	ath occur	red at the time,	date and placa,	end dua t	o me cause(s)	
within 2 To the comple	29b. Signeture end title of certifie	-			29	c. Licens	e number			29d. Date signe	d (Month,	Day, Year)	
FSFO	DAA AL	450-	110			D	2571	1	13.3	9117	1120	OU	
	776.10	×314	700	20-1 (7	Delen	U	24	•		1111	120		
	30. Name and eddress of person	wno complated caus	or death (Item 2	1	1		01		7) and and	it.	MD 2157 .	
	Mokhtar N	asir,	404 6		hiupti	de	KG 7	vite	10	Ues Mily	IH-	MD 3107 -	
State	31. Date filed (Month, Day, Year)		tegistrar's Signatu	L'	1 1	son	Kal						



State of Maryland / Department of Health and Mental Hygiene 0 0 32296

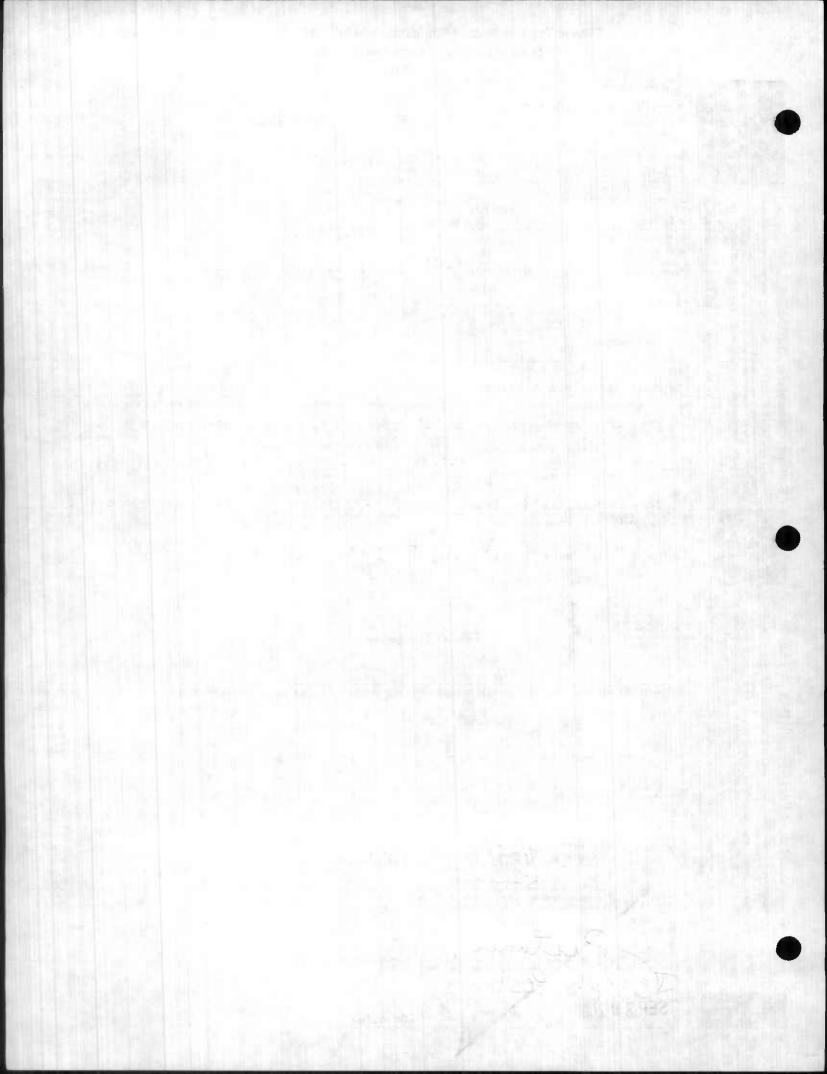
			Ce	ntificate of	Death		Reg. No.				
Physician /Medical	Decedant's Name (First, Middle, La Ricardo Montesin					2. Data of De Month SEPTEN	ath IBER 26,	2000	3. Time of Death 12:05 A.M		
Examiner	4e Facility Name (If not institution, gi ROUTE 155 and W		IDERM ROAD			or Location of Deetle GRACE	4c. County HARFO				
Funeral Director	223-89-0132	Sex 7. Ago 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e (In yrs. last birthday Yrs.	Months Days			th ly, Year) , 1981	9. Birthpla Counti Mexic	ace (Stata or Foreign ry) CO		
Maryland of show fied at	Usual Residence of Decedent 10a. Stete 10b. County Delaware New Cas	stle	10c. City, Town or L	ocation	1619		AND	10	d. Inside City Limits		
ath with the Maryle 23a or 28a-f shor sat be notified at ral Director	10e. Street and Number 55 Egret Court		NGW23	10f. Zip Code 19702			10g. Citizen of V Mexico	Whet Count	ry?		
ter do	11. Maritat Status 1 ☑ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedant Armad Forcas? 1 Yas 2 If Yes, Give Yeer or Detes:		Was Decedent of If Yas, specify Cut 1 ☑ Yes 2 ☐ No	oen, Mexican, Pu	(Specify Yes or No erto Rican, atc.) exican		e - America ck, White, e			
of 2 should be filed within 72 hours at the and Mental Hygiene. The marked other than "natural", or traumatic event, the Medical Exam To Be Completed by 8	15. Decedent's E (Specify only highast gr Elementery/Secondery (0-12)		+) (Give	dent's Usuet Occu s kind of work done DO NOT use retire	petion during most of a ed)	working	16b. Kind of Bu				
id be filed ental Hygis ted other ic event, II	12 17. Father's Neme (First, Middle, Lass Reynaldo Montesi			lema (First, Middle	, Maiden Sumam						
Pages 1 and 2 sho sent of Health and 1 ritt if flow 27 is me ry or other traums	19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State. Roberto Montesinos Perez/Brother 55 Egret Court, Newark, Delaware 19702 20e. Method of Disposition 1 Buriat 2 (Acremation 3 Removal from Stata 4 Donetion 5 Other (Specify) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State. 19c. Delegation of Delegation (Name of cemetery, crematory or other place) 19c. Mailing Address (Street and Number or Rural Routa Number, City or Town, State. 19c. Delegation of Delegation of Delegation (Name of cemetery, crematory or other place) 19c. Mailing Address (Street and Number or Rural Routa Number, City or Town, State. 19c. Delegation of Delegation of Delegation of City or Town, State. 19c. Mailing Address (Street and Number or Rural Routa Number, City or Town, State. 19c. Delegation of Delegation of Delegation of City or Town, State. 19c. Delegation of Disposition (Name of cemetery, crematory or other place) 19c. Mailing Address (Street and Number or Rural Routa Number, City or Town, State. 19c. Delegation of Delegation of Delegation of Delegation of City or Town, State. 20c. Location of City or Town, State. 19c. Delegation of Delegation of Delegation of City or Town, State. 20c. Location of City or Town, State.										
Department of the partment of	21. Signature of Funeral Service Lice	nsee 3. Hicko	H 1	2. Name end Addr icks Home 03 W. Sto	ess of Facility for Function St	erals, P.	A. ton, Mary	yland			
Physician /Medical Examiner	23e. Pert1. Enter the disaese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of):										
nding physician and use as the bunal-transit n/Medical Examine	Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury thet initiated events resulting in death) Last	C	Due to (or es e conse					1			
the death by the atte tached for thysicia	Part II. Other significant conditions	23b. Did	the cause of death?								
The law requires the sate has been signed page 2 should be del			perfe	an autopsy ormed?	con of d	re autopsy findings illeble prior to nplation of cause leeth?					
ysician: is certific director.	25. Was casa referred to medicat examiner? 1 \(\int \forall \gamma_1 \text{\$\gamma_2\$} \text{\$\gamma_2\$} \text{\$\gamma_0\$} \text{\$\gamma_0\$} \qq \qq \qq \qq \qq \qq \	Hospitel: 1Inpatie	nt 2 ER/Outpatia	nt 3□ DOA O	th a s	Deeth (Check only	idence 6 Both		SCENE		
eath. or: After the fune	27. Menner of Deeth 1 Neturat 5 Pending investigetic 3 Suicide 6 Could not to determine determined.	286. Plece of Inju- building, etc	28b. Time Injury Injury At home, ferm, s (Specify)	ury et ork? Yas 2 No	Vehicle 281. Location		swith ber or Aural te 15				
Hospi 24 hour Funer stely fill		hysician: To the best of miner: On tha basis of end menner sta	examination and/or le			ace, and due to the	ceuse(s) and me	enner as sta			
To the To the comple	29b. Signeture and title of eadifier	tane	_,M.		o.C.M.E.		29d. Date signe SEPTEMB				

State Registrar

erson who completed cause of deeth (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

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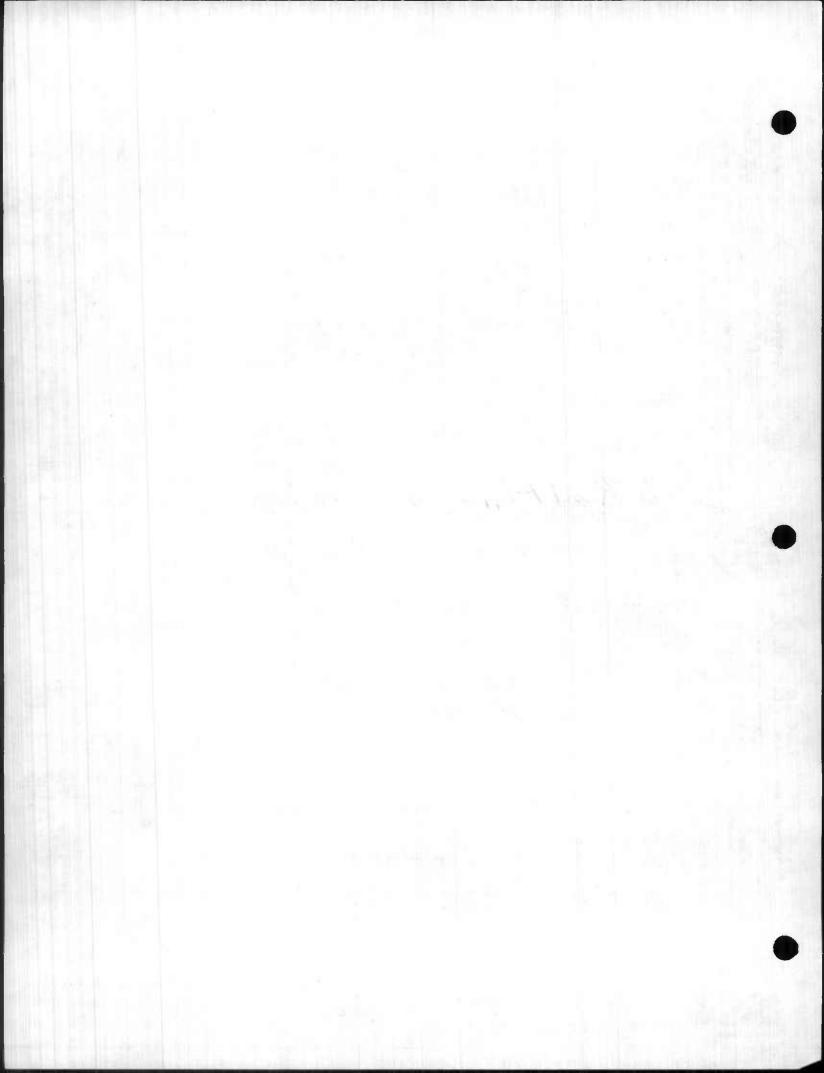


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev Year **Physician** PARROTT **JAMES** HOOPER 4:30 PM 23 2000 SEPT. /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** SALISBURY 515 PARK AVENUE Birthplace (State or Foreign Country)
 MARYLAND If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) MAR. 7,1915 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Hours 11 M 2□ F Vrs 85 Director 163-16-5344 Usuel Residence of Decedent with the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or hems 23s or 28s-f show odical Examiner must be notified at 1X Yes 2 □ No Director MARYLAND WICOMICO SALISBURY 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code U.S.A. 515 PARK AVENUE 21801 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11 Maritel Status 1 X Yes 2 No WWII If Yes, Give Yeer or Detes: Army 72 hours after 1 Never Merried 2 Married 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Army Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) OWNER/ OPERATOR SALVAGE 12 Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Peges 1 and 2 should be fill Department of Health and Mental H Important: if Nem 27 Is marked oft any loury or other traumatic svan Bates. Be Peges 1 end 2 should be nent of Health and Mental HARVEY MADISON PARROTT MABLE HOOPER 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) SHIRLEY PARROTT - WIFE 515 PARK AVE. SALISBURY, MARYLAND 21801 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 9/25/00 CAMBRIDGE, MARYLAND CAMBRIDGE CREMATORY 22. Name and Address of Fecility 21. Signeture of Funeral Service Licensee 705 E. MAIN ST. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line. SALISBURY, MD 21804 Approximate Intervet Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting In death) /Medical 4ears cardomyopathe Examiner Due to (or as e consequence of): Examiner death certificate be asscuted Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? PO Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings eveilable prior to Completed 24a. Wes en eutopsy performed? completion of cause of deeth? 28 No Division of Vital Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 10 1 Yes No this 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 28a. Dete of tnjury (Month, Dey Year) Certification: After Neturel or Attending 5 Pending investigation n 24 hours after death.

• Funeral Director: Af bletely filled in by the fu 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Hospital edical Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end menner es stated.

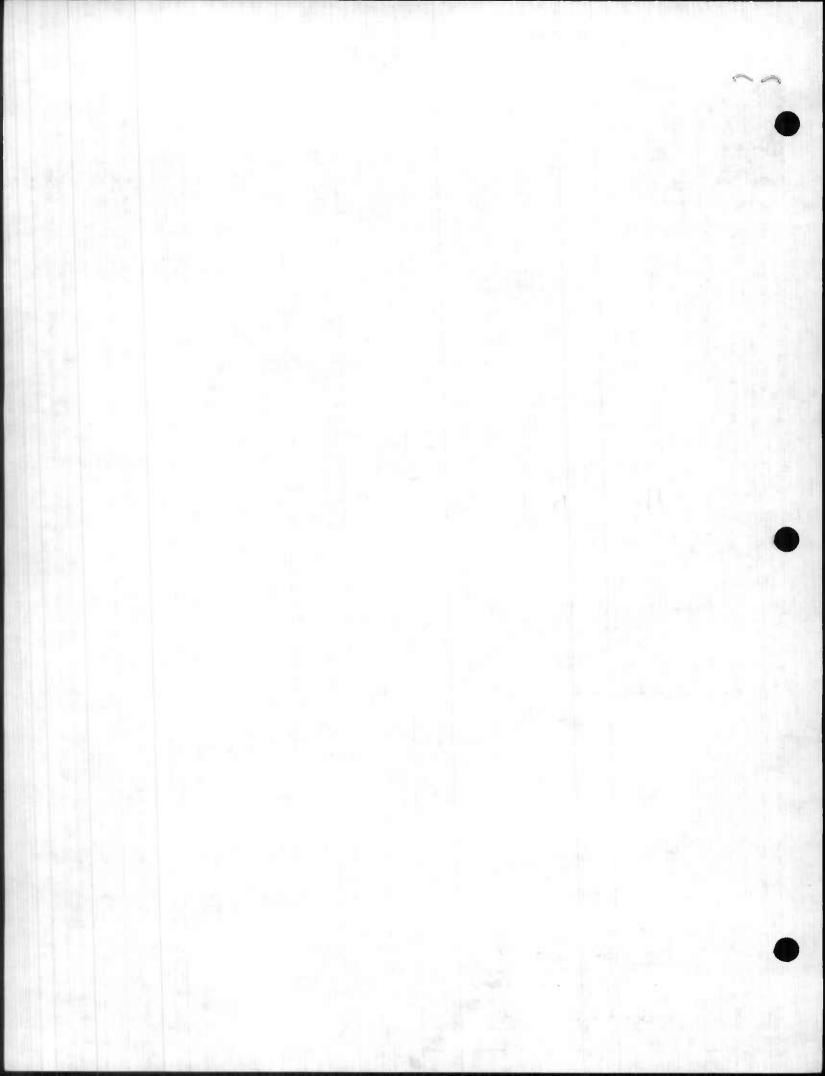
2 Nedical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end menner stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) Ž 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and title til certifier 30853 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Power Street Salisbury ND 21804 Silvia

State Registrar 32. Figuistrar's Signature



State of Maryland / Department of Health and Mental Hygiene

		Certificat	e of Death		Reg. No.	32298			
SI :	Decedent's Neme (First, Middle, Last)			2. Date of Dec		3. Time of Death			
Physician /Medical	DORIS GLORIA ROBERSON			Septemb	er 23,2				
Examiner	4e Fecility Neme (If not institution, give street and number)		4b. City, Town, or	Location of Death	4c. County	of Deeth			
	7748 Bender Road		Landove			e George's			
neral	5. Sociel Security Number 6. Sex 7. Age 1 ☐ M 25 F	(In yrs. lest birthday) If Under Months	1 Year If Under 24 Hrs Deys Hours Min	(Month, De)		Birthplece (State or Forei Country)			
ector	Usuet Residence of Decedent	59 Yrs.		Aug. 12	2,1941	Washington, D			
anow See	10s. State 10b. County	10c. City, Town or Location				10d. Inside City Limit			
Sector ector	Maryland Prince George's	Landover			1⊠ Yes 2□				
	10e. Street and Number	10f. Zip	Code	75	10g. Citizen of W	het Country?			
al Di	7748 Bender Road	20	0785		U.S.A.				
Funeral	11. Marital Status 12. Wes Decedent E Armed Forces?		tent of Hispanic Origin? (Sify Cuben, Mexican, Puer	Specify Yes or No-	14. Race	- American Indien, c, White, etc.			
	1 Never Married 2 Married 1 Yes, Give	0	2 No Specify:	to riloan, oto.,		Black			
d by	3 Widowed 4 Divorced Yeer or Dates:	1010	ZES NO Openny.		Specify.	Didon			
Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usue (Give kind of wo	al Occupation rk done during most of wo se retired)	rking	16b. Kind of Bu	siness/Industry			
ompl	Elementery/Secondery (0-12) College (1-4or 54	+)		343.51	Correme				
	12th	Secret		me (First, Middle,	Govern				
B	17. Fether's Neme (First, Middle, Last) Winon Jones		Cather			9)			
5		1				Out To Out 1			
trsumatic avent	19e. Informent's Neme/Reletionship (Type, Print)		(Street end Number or R						
o one	Daniel Roberson/Husband 20e. Method of Disposition	20b. Place of Disposition (Ner	er Road, Lan	dover, M		20785 City or Town, State			
	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete	cemetery, cremetory or o	ther plece)	09/29					
ouce.	4 □ Donetion 5 □ Other (Specify)	Harmony Memor		2000	Landover	, Maryland			
puce	21. Signeture of Funeral Service Licensee	J.B. JI	d Address of Facility ENKINS FUNER	AL HOME					
	Nancy A. Percen	tre 7474 La	andover Road	, Landov	er, Mary	land 20785			
	23a. Pert1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the deeth. Do not enter the mod e.	e of dying, such es cardia	c or respiretory er	rest,	Approximate tntervat Between Onset end Death			
ian cal	In the Course (First								
er	Immediate Ceuse (Finet disease or condition resulting in deeth) Metasta	tic Colon Cance	er			10 Months			
-		Due to (or es e consequence of):							
Examiner	b								
al Examir	Sequentialty list conditions, if eny, leeding to immediate	Due to (or es e consequenca of):							
	Cause: Enter Underlying Cause (Disease or injury that initiated events	quentialty list conditions, in the properties of							
edical	resulting in deeth) Lest	Due to (or as a consequenca of):							
clan/Me	d								
Physician/M	Pert It. Other significant conditions contributing to death but	t not resulting in the underlying o	ause niven in Pert I	23b. Dld 1	obacco use con	tributa to the causa of de			
Physic						3 Probably 4 Unk			
should be del				24a. Wes	an eutopsy med?	24b. Were eutopsy findin eveilebte prior to			
z sno				pono		completion of cause of deeth?			
Completed				101	res 2 🖾 No	1 ☐ Yes 2 ☐ No			
Be C	25. Wes case referred to medical		26. Place of De	eth (Check only o	ne)				
ToB	examiner? 1 ☐ Yes 2 ☒ No Hospitel: 1 ☐ Inpatier	nt 2 ER/Outpetient 3 DC	Other	Home 5 N Resid		or (Specify)			
	27. Menner of Death 28a. Date of Injury	/ 28b. Time of 2	28c. Injury at Work?	7	now injury occurr				
Certification:	1 ☑ Neturet 5 ☐ Pending (Month, Dey 2 ☐ Accident investigation	Year) tnjury M	1 Yes 2 No						
100	a Could not be	ry - At home, ferm, street, fector	, office	28f. Location (S City or Tox	Street and Number	er or Rurel Route Number,			
Seri	ounding, etc.	(5,000))		0.1, 0. 101	,,				
Medical Certifi	29a. Certifier (Check only 2 Medical Examiner: On the basis of								
edical	(Check only one) 2 Medical Examiner: On the basis of end menner stet		, in my opinion, death occ	urred et the time,	date end pieca, s	and due to the cause(s)			
Σ	29b. Signeture and flux at conflipr		c. License number			(Month, Dey, Year)			
_	heelber	D	30666		Septembe	er 26, 2000			
	30. Name and address of person who sumplited cause of de								
	John Badeau, M.D., 1450 M	erchantile Land	e, #217, Lar	go, Mary	land				
State	31. Dete filed (Month, Dey, Year) 32. Registre	r's Signeture							
gistrar	SEP 2 9 2000	& Span							
v 6/95	,4	1 JOHN	4						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** Se 24, 2000 TERRY KENNEDY RYALS /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1tz atosville LAMONT Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 180 M 2□ F 579-06-2525 32 Director June 5, Maryland Usual Residence of Decedent the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow 1 Yes 2 □ No Director Maryland Prince George's Hyattsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code naturel', or items 23a or 6411 Lamont Drive 20784 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health and Mentel Hygiene. Introduce in the marked other than "natural, or from any injury or other treumatic event, the Medical and Mode. Black, White, etc. 1 X Yes 2 No If Yes, Give 11 Never Merried 2 Married Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: P 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12th Counselor Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emily J. Wallace John Ryals 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily J. Cash/Mother 6411 Lamont Drive, Hyattsville, Maryland 20784 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 10/03 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2000 Maryland Veterans Ceme. 21. Signature of Funeral Service Licansee J.B. JENKINS FUNERAL HOME Nance 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such es cardiac or respiretory arrest, shock, or heer failure. List only one cause on each line. Approximate tnterval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) Neumonia /Medical Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last the deeth certificate be execu Box 68760. Physician/Medical Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Onknown signed I Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examine?

127es 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1. Natural 5 Pending ne Hospital or Attending n 24 hours efter deeth. The Funeral Director: Afte pletely filled in by the fun 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

**Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) SHIVAdon 3001 Hos 32. 31. Dete filed (Month, Day, Year) Registrar's Signature State SEP 2 6 2000 Registrar

Certificate of Death

2:45 PM

1 Yas 2 No

7 is marked other than "natural", or items 23s or 28s-f show traumstic svent, the Medical Examinar mast be notified at 5-0020 Pages 1 and 2 should be filed wrom-ment of Health and Mental Hygiene. 2121 Important: If Itam 27 is marked other any Injury or other traumatic avent, tronce. Baltimore, Maryland

Be

TO PHYSICIAN:

NAME KNOWN

RIDGLEY

CHARLES

Physician /Medical Examiner

burial-transit The law requires that the death certificate be executed and Box 68760, P.O. been signed by the should be detach Records, page 2 this

Examiner Physician/Medical p Completed Division of Vital or Attanding Physician: Be Certification: To funeral After death. 24 hours after deat Funeral Director: filled in by Hospital edicai

1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month Year Carl Stansbury Ridgeley SEPTEMBER 24, 2000 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death NT 8. Data of Birth (Month, Day, Year) Second 13, 1919 VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECTL If Under 1 Yaar Birthplace (Stata or Foreign Country) 5. Social Security Numbar Aga (In vrs. last birthday) Months Days Hours 101M 20 F 219-01-1461 81 Maryland Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland Cecil Port Deposit 10e. Street and Number 10f. Zio Coda 10g. Citizan of What Country? 15 Green Lane 21904 U.S.A. 14. Raca - Amarican Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 Navar Married 2 Married 1 X Yas 2 No If Yas, Giva Yaar or Datas: 1943-45 1 ☐ Yas 2 🖾 No Specify: Specify: 3™Widowad 4 Divorced Black. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry V.A. Medical Center Elementary/Secondary (0-12) Six Years Collaga (1-4or 5+) Perry Point, Maryland Nurses Aid 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Robert Ridgeley Beatrice Stansbury 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Bertha I. Jackson 79 Cokesbury Road, Port Deposit, Maryland 21904 20b. Piace of Disposition (Nama of cemetery, crematory or other place) 20a Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata Berkley Cemetery 9/28/00 Darlington, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licante 22. Nama and Addrass of Facility Lee A. Patterson & Son Funeral Home, P.A. DOX. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata tntarval Batween Onsat and Death Immediata Causa (Final SEVERE BACTERIAL PNEUMONIA disaasa or condition rasulting in daath) UNKNOWN Dua to (or as a consaquance of): SEVERE SEPSIS UNKNOWN Sequantially fist conditions, if any, laading to immadiate causa. Entar Undarlying Cause (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequanca of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 3 Probably 4 XUnknown 1 ☐ Yes 2 ☐ No 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 X No 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 1 Monpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of fnjury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Panding 1 Tas 2 No Invastigation 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida

200 within 2 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year)

D42014

SEPTEMBER 25, 2000

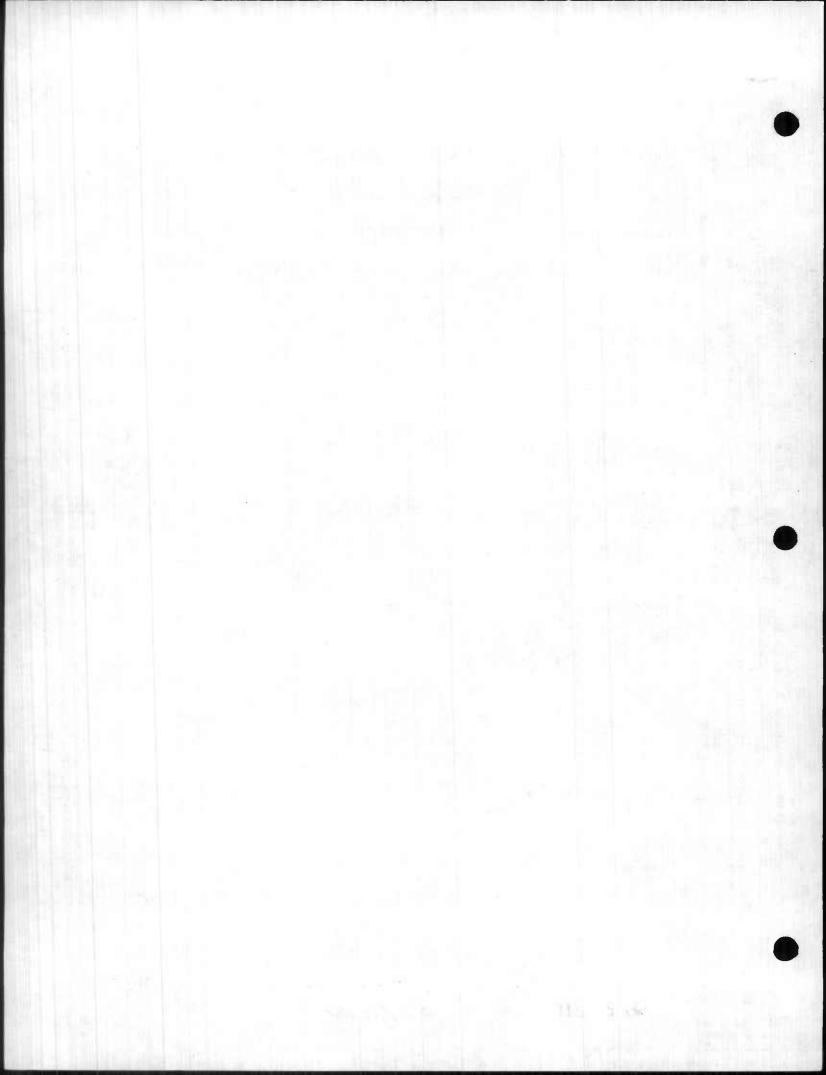
30. Nama and addrass of person who complated cause of daath (Item 23a) (Type, Print)

SURINDERPAL SODHI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902 31. Data filed (Month, Day, Year)

State Registrar

29a. Cartifian (Check only one)

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time f leath Month UISC. Rellins 0945 01 2000 DETCHEN 4e. Facility Name (If not Institution, giva street and numbar) 4b. City, Town, or Location of Deeth 4c. County of Deeth UNION HOSPI ELKTON ECIL 5. Sociel Sacurity Number If Undar 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year)
SETTEMBER 12, 1933
9. Birthplace (Steta or Foraign Country)
COCKYSVILLE, MD 6 Say 7. Aga (In yrs. lest birthday) 10 M 20 F Months Days Hours 216-30-5282 6 7 Yrs. Usual Rasidance of Dacadani 10a Stata 10b County 10c. City. Town or Location 10d. Insida City Limits CECIL MARYLAND 1 Yas 2 No ELKTON 10g. Citizan of What Country? 10e. Straat and Number 10f. Zip Coda #4 21921 ING WAY WITND USA 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Datas: 14. Race - American Indien, Black, White, etc. 13. Was Decedant of Hispanic Orlgin? (Spacify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Navar Married 2 Married 1□ Yas 2♥No Spacify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation

16a blood of work done during most of working 15. Decedant's Education (Spacify only highast grada completed) 16b. Kind of Businass/Industry (Give kind of work dona life. DO NOT use retire. Elementery/Secondary (0-12) Collega (1-4or 5+) REGISTERED NULSE 12 3 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fethar's Nama (First, Middle, Last) JR. WILLIAM LEE VIOLE SOHNSTON 19a. Informent's Name/Ralationship (Type, Print) 14453 and 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) #4 WINDING WAY COKTON, MD 21921 TUDGE EDWARD D. E. ROLLINS, JR 20b. Plece of Disposition (Nama of cematary, cramatory or other place)

TMA LUATE CONSETERMENT OF THE TOPY 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata 10/4/00 CHERRY HILL, MARYLAM 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name end Address of Fecility 259 E. MAIN ST. LIKTON ease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiretory errest, me. List only one cause on each line. Approximata Interval Between Onsat end Death Immadiata Ceuse (Final Hypertenison disaasa or condition rasulting in deeth) plande Sequentially list conditions, if any, laading to Immadiate causa. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or es e consaquance of): COPD Due to (or as e consequence of): Pert It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 robably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Ware autopsy findings evellabla prior to complation of causa of deeth? 24a. Was an autopsy performad? 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical axaminer? 26. Placa of Death (Chack only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Xinpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 27. Mennar of Death Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Dascribe how injury occurred 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant

Examiner Examiner be axecuted burial-transit and P.O. Box 68760, attanding physician Physician/Medical the signed by t à Completed this certificata Be Medical Certification: To After after death. in by

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ò death with

"natural", or Items 23a

pernit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiena. Important: If item 27 is marked other than any Injury or other traumetic event

Physician /Medical Director

Funeral

P

Completed

traumatic event, the Medical Examiner must be notified at

the Maryland

72 hours after

Baltimore, Maryland 21215-0020

Records, Division of Vital To the Hospital or Attanding Physician: hours aftar within 24 hours a

31. Data filed (Month, Dey, Yaar) State Registrar OCT 0 3 2000

3 Suicida

29a. Cartifiar

4 | Homicida

29b. Signature end titla of partifier

6 Could not be daterminad

28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

29c. Licansa numbar

STREET

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29d. Data signad (Month, Day, Yaar)

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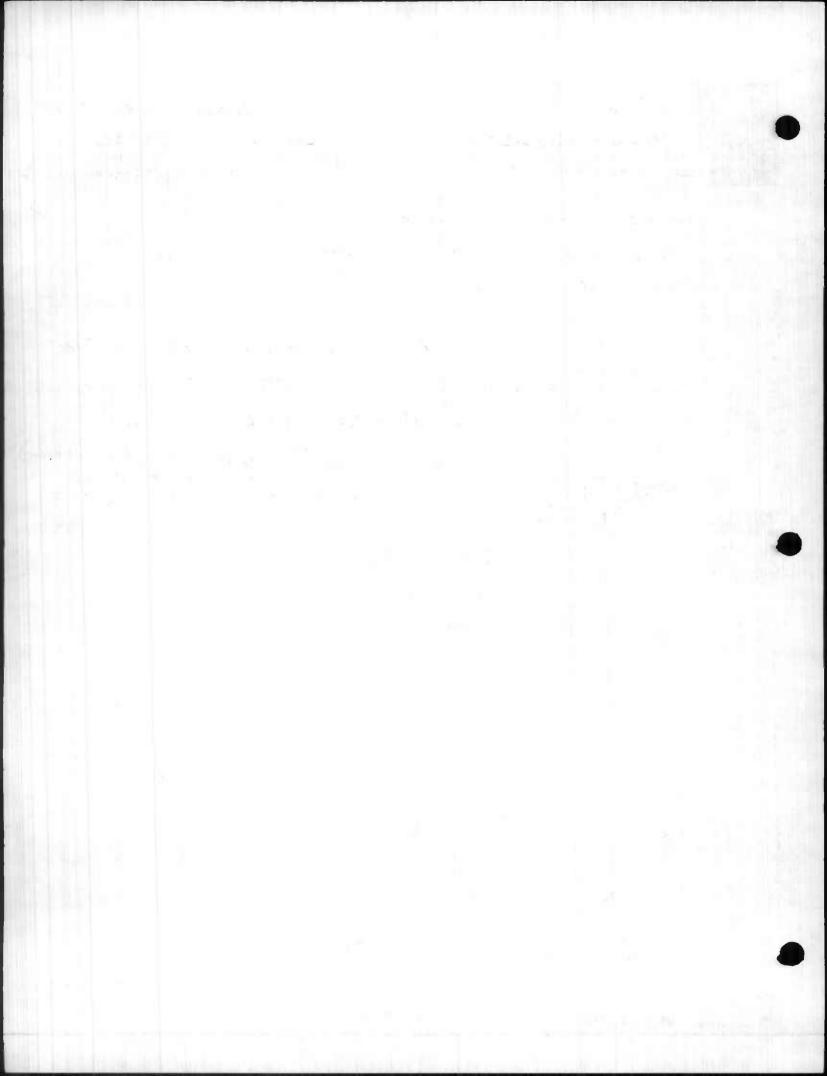
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

Middle town, Do

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

Covell William 817 N. BROXD

32. Registrar's Signatura



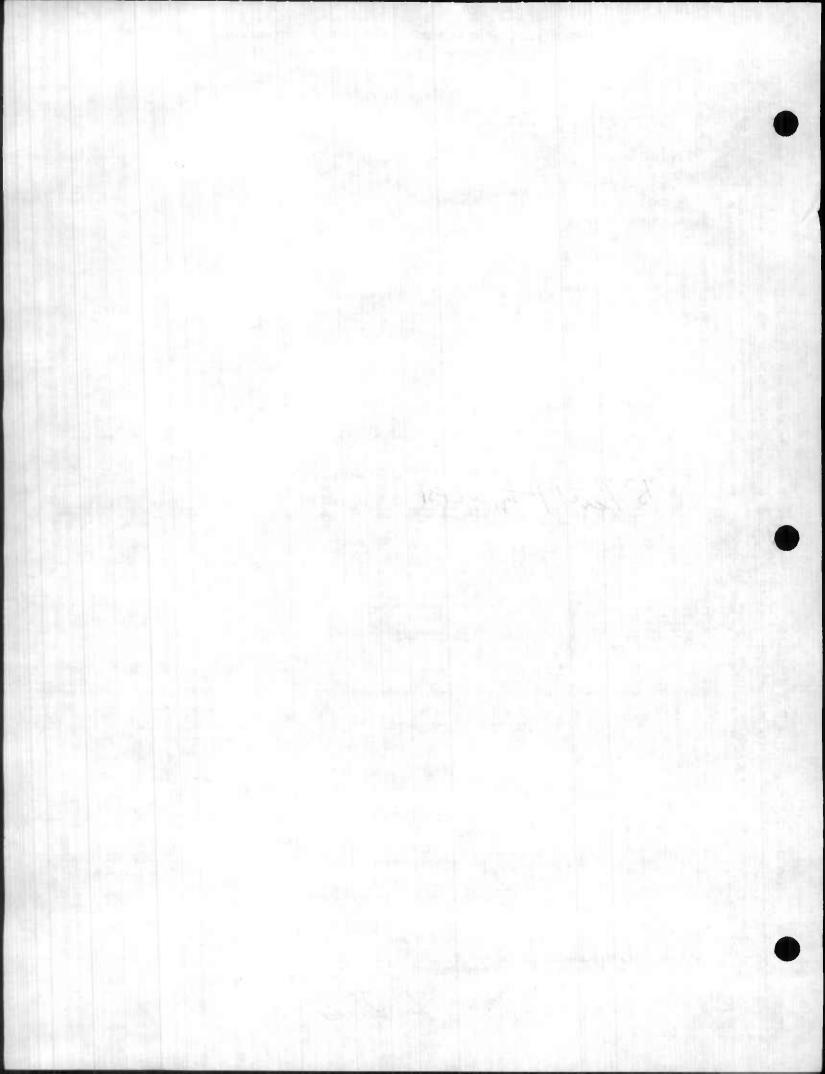
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State of Maryland / Department of Health and Mental Hygiene

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiens. Important: If flem 27 is merited other than "natural", or the Baltimore, Maryland 21215-0020 Phys /Me Exan To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

Physician	1. Decedent's Neme (First, Middle, I						2. Deta of Deeth Month SEPT	Dev	Year	ima of Death				
/Medical	MILTON THOMAS		-10-4			4b. City, Town, or Lo		25 , 20 4c. County		046 AM				
Examiner	4e Facility Neme (If not institution, g PENINSULA REGIO		CENTER	?		SALISBUR		1	MICO					
Funeral Director	5. Social Security Number 6 216-40-3422 Usuel Rasidenca of Decedant	Sex 7. Agr	a (In yrs. last b	Yrs. If Under Months	1 Yaar Deys	If Undar 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey, FEB. 3,		9. Birthplaca (Country) DELAWAI	State or Foreign				
ě u	10e. Stete 10b. County		10c. City, To	wn or Location		A Decree			10d. In	side City Limits				
unled unled ctor	MARYLAND WICOMI	CO	SA	LISBURY					1[Yes 2X No				
or 28a-fr	10e. Street and Number			10f. Zip	Code		10	og. Citizen of V	Whet Country?					
e 23e mat oral	1618 MT HERMON R			140 1/1- 0		1804		U.S.A.	J. S. A. 14. Race - American Indian,					
er, or thems 23s Examiner must by Funeral	Never Merried 2 Married Widowed 4 ☑ Divorced	12. Wes Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Yeer or Detes:	O AIR FORCE	If Yas, spec		lispenic Origin? (Spen, Mexican, Puerto Specify:	Rican, etc.)		ck, White, etc.					
dical dical	15. Decedent's (Specify only highest of	Education prada completed)	16	16a. Decedent's Usuel Occupetion (Give kind of work done during most of w				16b. Kind of Bu	usiness/Industry	, , , , , , , , , , , , , , , , , , ,				
t, the Medical	Elementery/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT us	se retired	d)								
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o Be						VIRGINI		HUD						
To	MILTON A RU 19e. Informent's Neme/Relationship	ARK (Type, Print)	19	b. Mailing Addrass	(Street	end Number or Run)				
M. ILW	SANDRA R. HALL -			9246 HALI			LLWOOD,		359					
	20a. Method of Disposition 20b. Place of Disposition (Name of Dispositio													
so kinjur e	1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) PITTSVILLE CEMETERY 9/30/00 PITTSVILLE													
etached for use as the burial-transit and leading the burial-transit bhysician/Medical Examiner	23e. Parf1. Entar tha disease, or co shock, or heert failure. List on Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in deeth) Last	a. Multip b	le Ini	tonsequence of):					Intan	oximata val Batween et end Death				
ysic	Part II. Other eignificant conditions	contributing to death bu	it not resulting	in the underlying c	ause giv	ren in Pert I.			ntributa to the o					
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leted							24a. Was er perform	n eutopsy ned?	available	on of causa				
Com							1 Deye	s 2 No	DELYes	2 No				
certific irector	25. Was casa referred to medical examiner?				140	26. Plece of Deet	h (Check only on	a)		m				
	1⊠ Yes 2□ No	-	nt 2 ERVC			4 Li Nursing no	ma 5 Reside							
	27. Manner of Deeth 1 □ Neturel 5 □ Pending	28a. Dete of Injur (Month, De)	Year)	3.4	8c. Injur Wor	k? Yes 2/ENo	mater wehi							
		Accident investigation Suicida Gould not be datermined Suicida Gould not be datermined Suicida						per or Rural Rou Ker Rd	ta Number,					
· ·	Accident investigeti	28a. Place of Inju- building, etc	. (Specify)	street	29a, Certifiar (Check only (Ch									
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五百	Accident 3 Suicida 4 Homicide 29a. Certifiar (Check only one) (Check only one)	Physician: To the best of and menner sta	f my knowledg examinetion e tad.	She et pe, deeth occurred ind/or invastigation,	Licens	pinion, daath occuri	ed at tha time, de	ete and pleca, Od. Data signe SEPT.	d (Month, Dey, 25, 20)	Year)				

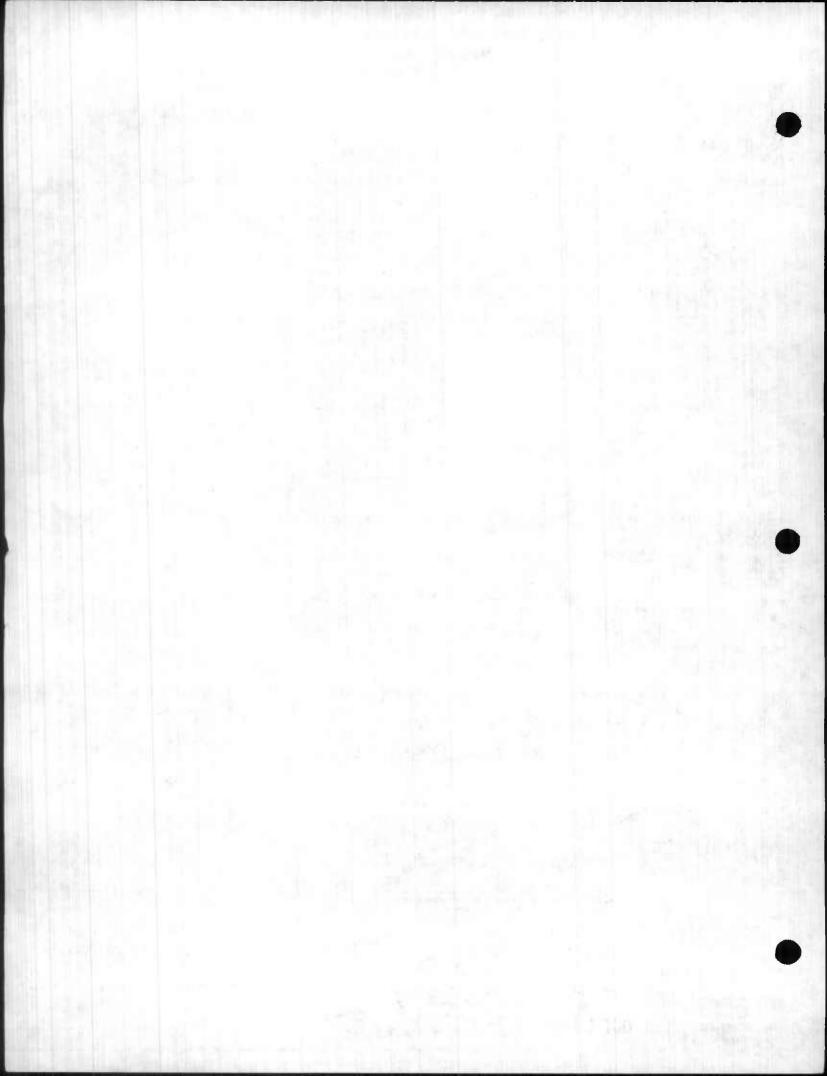


REP

State of Maryland / Department of Health and Mental Hygiene 10 22202

LACEM	ENT					Certificate	of Dea	ath		Reg. No.	U	12303		
		1. Decedent's Name (Fi	rst, Middle, La	st)		,			2. Data of Dea		Year	3. Time of Death		
	Physician /Medical	Russell	Nathanie	el Robert	ts				AUGUS-	r 18	2000	0937		
<u>k</u>	Examiner	4a Facility Name (If not					4b. Cit	y, Town, or L	ocation of Death	4c. Cour	ty of Death			
		The Memorial						ston		Tal		MILE LO		
1	Funeral Director	5. Social Security Numb 214-12-5496		Sax IM 2□ F	je (In yrs. lest b	yrs. If Under 1		nder 24 Hrs. ours Min.	8. Date of Birt (Month, Da June 15,		9. Birthp Coun Maryla	place (Stete or Foreign http)		
-	1.	Usual Residence of Dec	edent c. County		10c. City, To	wn or Location				Od. Insida City Limits				
a Mand	or 28a-f show be notified at Director	MD	Talbot			ppe		Br.				1 AYas 2 □ No		
-	0 H 20	10e. Street and Number 4070 Hennis		ne			1673			10g. Citizan of What Country? USA				
21215-0020	Examiner in I by Funer	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Decedent Armed Forces? 1 Yas 2 Xi If Yes, Give Year or Dates:		13. Was Decede If Yas, specif	ic Origin? (Sp exican, Puarto ecify:	pecify Yes or No o Rican, atc.)	14. Race - American Indian, Black, White, etc. Specify: Black					
50	ypane. we then neture. It the Medical.	15. (Specify of	Decedent's Enly highest gri	ducetion ade completed)	16	a. Decedent's Usual (Give kind of work life. DO NOT use	Occupation done during	most of work	king	16b. Kind ot	Business/Inc	dustry		
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D 2	Baltimore, Maryland 2 nomit. Pages t and 2 should be siled a 2positimant of Health and Mertal Hygie moortant: if Item 27 is marked other t Ry Injury or other traumatic event, th 2026. To Be Co	17. Father's Nama (First	Middle I ast)		Care Take		Mother's Nam	ne (First, Middle,		imployed	1		
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7		19a. Intormant's Name/		Type, Print)	19	b. Mailing Address (er, City or Tow	m, Stete, Zip	Code)		
ME			Roberts		070 Hennis									
more,		20a. Method of Dispositi 1 X Burial 2 Cr. 4 Donation 5 D	emalion 3 [Removal from State	20b. Place cemet	of Disposition (Nemery, crametory or off			Date		on - City or Town, State			
alti		21. Signature of Funera				22. Name and Address of Facility Henry Funeral Home, P.A., 510 Washington St.								
00 8	A STATE OF	Janelle	C. Henry	Per DVR		neral Ho , MD 21	me, P.A	., 510 Wa	shington	St.				
		23a. Part1. Enter the di shock, or heart fail	sease, or com	plications that caused	d the death. Do				or respiratory a	rrest,		Approximate Interval Between		
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	/Medical xaminer	Immediate Cause (Fina disease or condition	5	Myoca	RDIAK	INF	-ARCT	TOL)			30 MINUTE		
	-	Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): ATHOROSCIEROSIS									410405			
e di C	g physician and as the butal-frensit	Sequentially list condition	ons.	b. IT INGIC	Due to (or as a	a consequence ot):	1			1	161703			
68760,	ian ar urial-t	Sequentially list condition if any, leading to immed ceuse. Enter Underlying Cause (Disease or injurithat initiated avants	liate 9	114 00	RIFIE	US(01)				YEARS				
68760,	physicians the burner edical	that initiated avants resulting in death) Last		C.		consequence ot):								
			L	d										
B.	igned by the attending be detached for use aby Physician/M	Part II. Other significant	conditions	ontributing to death b	ut not resulting	in the underlying ce	use given in	Part I	23b. Did	tobacco usa	contribute to	o the causs of death?		
P.O.	by the tached	0.418	-0	^		omer				Yes 2 KN				
S, S	be del	EWB ST	AGE	REWA	C 121	seme								
Records, P.O. Box	ate has been signed; pege 2 should t	DIABETE	5 M	GLITU	ST	YPE 1			24a. Was perfo	an autopsy ormed?	av	lere autopsy findings vailable prior to empletion of ceusa death?		
H H	pege 2	CALL TO SOL							10	Yes 2 No	1[□Yes 2 No		
		25. Was cese referred to examiner?	o medical				26.	Place of Dea	ith (Check only o	one)				
of Vita	this ce all direction To I	1 Yes 2 No		Hospital: 1 ☐ Inpatie	ent 2 ER/C	Outpatient 3 DOA		☐ Nursing H	loma 5□ Resi	dence 6 🗆 C	ther (Specif	<i>(y)</i>		
0 0	After th funeral	27. Manner of Death 1 Matural 5[☐ Pending	28a. Date of Inju (Month, De	y Year) 28b	. Time of 28 Injury	Work?		28d. Describe	how injury occ	urred			
Vision	deeth. ctor: A y the f	2 Accident	Investigatio			М	1 Tes	2 □ No	004 1 1	04		10		
	1 = 5 E	4 Homicide	determined	250. Place of inj	ury - At home, c. (Specify)	farm, street, factory,	office		28t. Location (Street end Number or Rurel Route Number, City or Town, Stafa)					
Di To the Hospital or	within 24 hours after To the Funeral Dir completely filled in Medical Cert			niner: On the basis of and manner ste	f examination a									
	To the control of the	29b. Signatura and titla	alla.	lleoske	con 1	is ign	Licanse num	609	?	AUGUS:	7 18	7,2000		
	-	30. Name and address of	of person who	completed cause of d	leath Human	(Type, Print) 503	suep	ST	CAMB	21868	M	D 21612		
	State Registrar	31. Date tiled (Month, Do			ar's Signature		rocks							
DUM	Life Day CDC	UCI	116	000		/ //	.30							

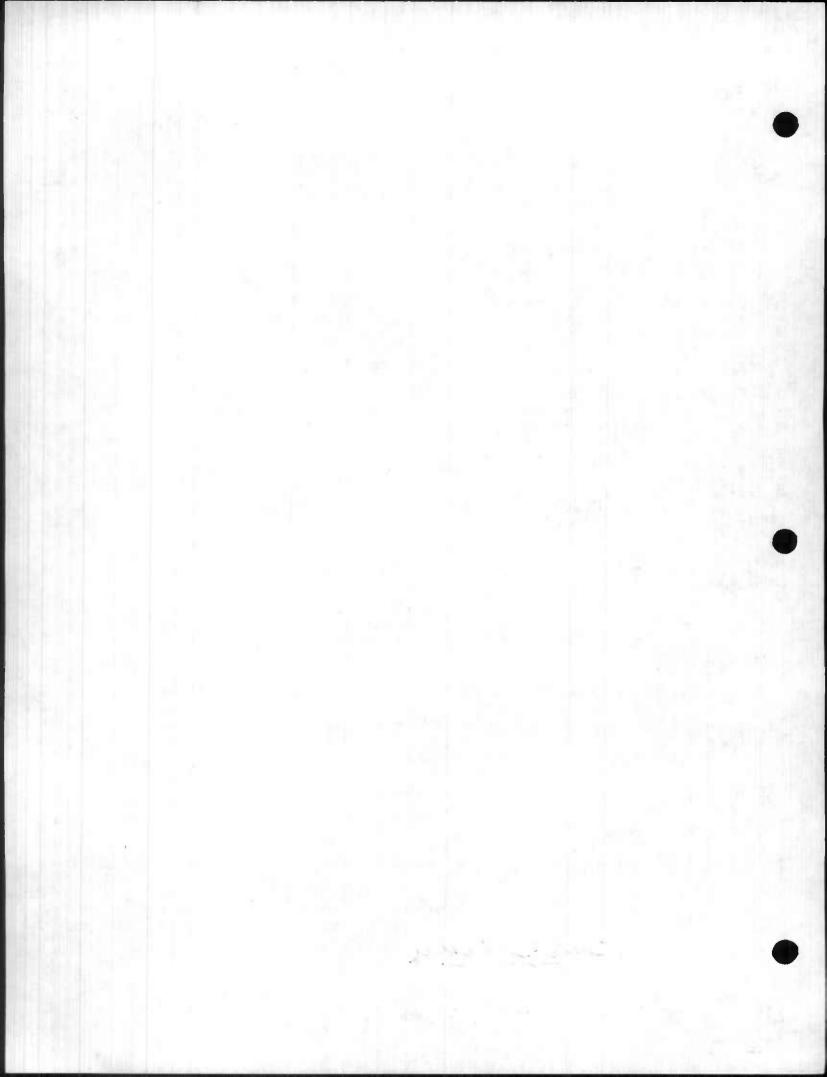
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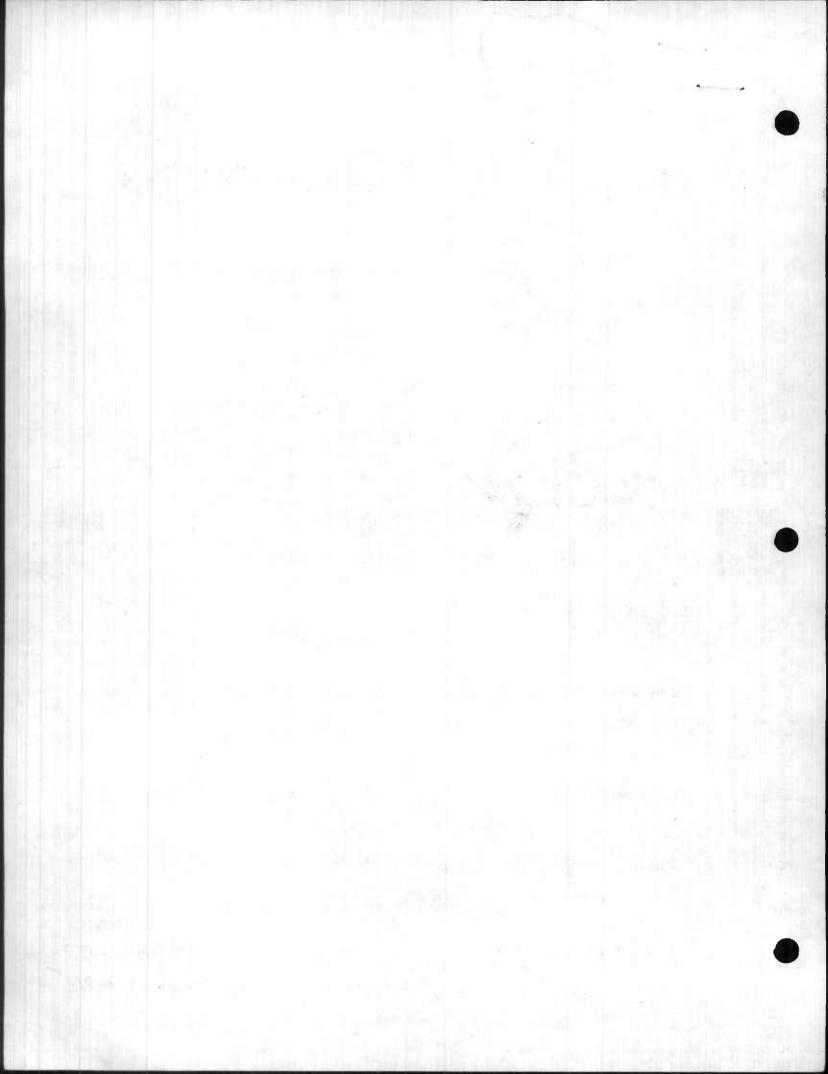
State of Maryland / Department of Health and Mental Hygiene

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			Ce	ertifica	te of	Death		Reg. No).	0 0	200	14	
Dhualalan	1. Decedent's Nama (First, Middle, Las		2. Data of Month			ıv	Year 3	3. Time of	Death				
Physician /Medical	MARGARET LOA	NE SUTHERL	AND										
Examiner	4a Facility Nama (If not institution, give	4b. City, Town, or Location of Daath 4c. County of Death											
	4950 Allan Road		201,27			Bethesda			ntgan				
Funeral	5. Social Security Number 6. Se	7. Age (in)	rs. last birthday	/) If Unde Months	r 1 Yaar Days		Min. 8. Date of I	Birth Day, Year)	,	9. Birthplace Country)	e (State o	r Forei	
Director	0.0 10 1001	× 93	Yrs.				October	26,1	906	washingt	on, D	.C.	
2	Usual Rasidance of Decedent 10a. Stata 10b. County	10c.	City, Town or I	Location	-	-				10d.	Insida Ci	ty Limi	
or or											1 Yas	2 🗆 N	
or 28a-fs be nouted	MD Montgome	ery	ethesda	10f. Zip Coda					tizan of W	Vhat Country	?		
D 50	4950 Allan Road			20816				USA					
natural, or items 23s or 28s-f show Mail Examiner must be notified at sted by Funeral Director	11. Marital Status	12. Was Decedent Ever i			lispanic Origin	? (Specify Yas or uarto Rican, atc.)	No-		e - Amarican				
or its	1 Never Marriad 2 Married	Armed Forcas? 1 ☐ Yas 2💢 No					uarto Rican, atc.)			k, Whita, atc.			
b v	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giva 1 ☐ Yas 25 Yaar or Dates:			2K No	Specify:			Specify	White			
ygiane. nor than "natural", rt, the Medical Ext. Completed by	15. Decedent's Ed		16a. Dec	edant's Usu	al Occup	pation		16b. K	(ind ot Bu	sinass/Indus	stry		
	(Specify only highest grade Elemantary/Secondary (0-12)	Collega (1-4or 5+)	(Give kind of work done life. DO NOT use retire			d) most of	working						
Hygiane. ther than " ent, tre the		4	Teac	Teacher						ic Schoo	ol Sys	item	
Tab o	17. Father's Nama (First, Middle, Last)					18. Mothar's	Name (First, Midd	lle, Maidei	n Sumam	Θ)			
	John T. Stansbury Loan	ohn T. Stansbury Loane Georgi						Alarc	dire				
DE E	19a. Informant's Name/Ralationship (7			19b. Mailing Address (Street			et and Number or Rural Route Nur			umber, City or Town, State, Zip Code)			
= 0 -	Sandra Woodall/friend					Bethesda	, MD 20816						
250	20a. Method of Disposition Burial 2 Cremation 3		 b. Piace of Disposers cematary, cr 	position (Na rematory or	me of other pla	се)	Data	20c. L	ocation -	City or Town	, Stata		
5 4 7	Donation 5 Othar (Specify		edar Hi	11 Ce	mete	ry	09/27/2	000 5	Suit	land, I	MD		
Depertment important any injure poce.	21. Signature of Funeral Service Licen	see		22. Nama a	nd Addra	ass ot Facility	CEDAR HII	L FUN	RAL F	ME. IN	C.		
0 = 9 9	Moral Uniton	en- Clen Hars	4	111 Pe	nsyl	vania Ave	.,Suitland						
/Medical xaminer	Immediata Causa (Final disaasa or condition rasulting in deeth)		o (or as a cons			isoaso							
as the bunal-transit	Sequentially list conditions	b. Severe Obstructive Lung Disease Dua to (or as a consequence of):											
an er iriel-ti	Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Diseasa or injury that initiated avants	Aspiration	ration pneumonia										
physician end is the burial-transit edical Examir	Cause (Diseasa or injury that initiated avants resulting in death) Last	Decubiti Ulceration								1			
~ ~ ~	Tubuling in Godin Cast												
for use	TO STORY OF THE STORY	d											
by the ettending atached for use a Physician/M	Part II. Other significant conditions co	entributing to death but not	rasulting in tha	undarlying	ceusa gi	van in Part I.	23b. D	ld tobacc	o uae co	ntribute to th	ne cause i	of dea	
ed by the datached							1	☐ Yes	2□ No	3 Probab	bly 🏝	Unkn	
58 5										Odb Word	autono. 1	tin elin.	
paga 2 should							24a. W	as an auto fromed?	opsy	24b. Were avails	abla prior to	lo	
has by ga 2 s										of dea	ath?		
paga paga Com							1	☐ Yas 2	No	1 🗆 Y	es 20	No	
entific Sctor	25. Was cesa reterred to medicel axaminar?						Death (Check on	ly one)					
T die	TUTAS AND NO			ent 3□ DOA Othar: 4□ Nursing Homa StartResidence 6 □Othar (Specify)									
rs after death. al Director: After t led in by the funera Certification:	27. Manner of Death 1- Natural 5 Pending	28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work?					28d. Dascril	oe how inju	ury occur	red			
the the	2 Accident Investigation 3 Suicide 6 Could not be		M 1 Yes 2 No					- (011	and Advanced		Davida Alver		
Director: Jin by the	4 ☐ Homicide datarmined	28a. Plece of Injury - / building, atc. (Sp	ecify)	streat, facto	ry, office		City or	Town, Stei	te)	er or Rural R	TOUTO /VUIT	iber,	
n 24 hours after death he Funeral Director: pletaly filled in by the edical Certifical	29a. Certifier Check only one) Certifying Physics Check only one)	rsician: To the best of my iner: On the basis of exan and mannar stated.	knowledga, dae ninetion end/or	eth occurred investigatio	d et tha ti n, in my	ime, date end p opinion, daath o	elece, end due to to occurred at the time	ha causa(s na, date ar	s) and me nd place,	enner as state and due to th	ed. ne cause(s	s)	
Me Me	29b. Signatura and titla of certifiar			25	e. Lican	se number		29d. D	ata signa	d (Month, Da	y, Year)		
(12)	1 Carl	Elic	de	14	MD	056065		9/18	3/200	00			
///	30. Nama and addrass of person who d		4.	o Drine)									
10)						1105 =	-	-		4.5			
State	Carlos F. Picone, 31. Data tiled (Month, Day, Year)	32. Registrar's S	natura /	III_AV	= . #	1125 Ch	evy chas	e, ML		1.1.5		_	
State	SED 2 6 2000	Bagners 1	. Am	a V	,								



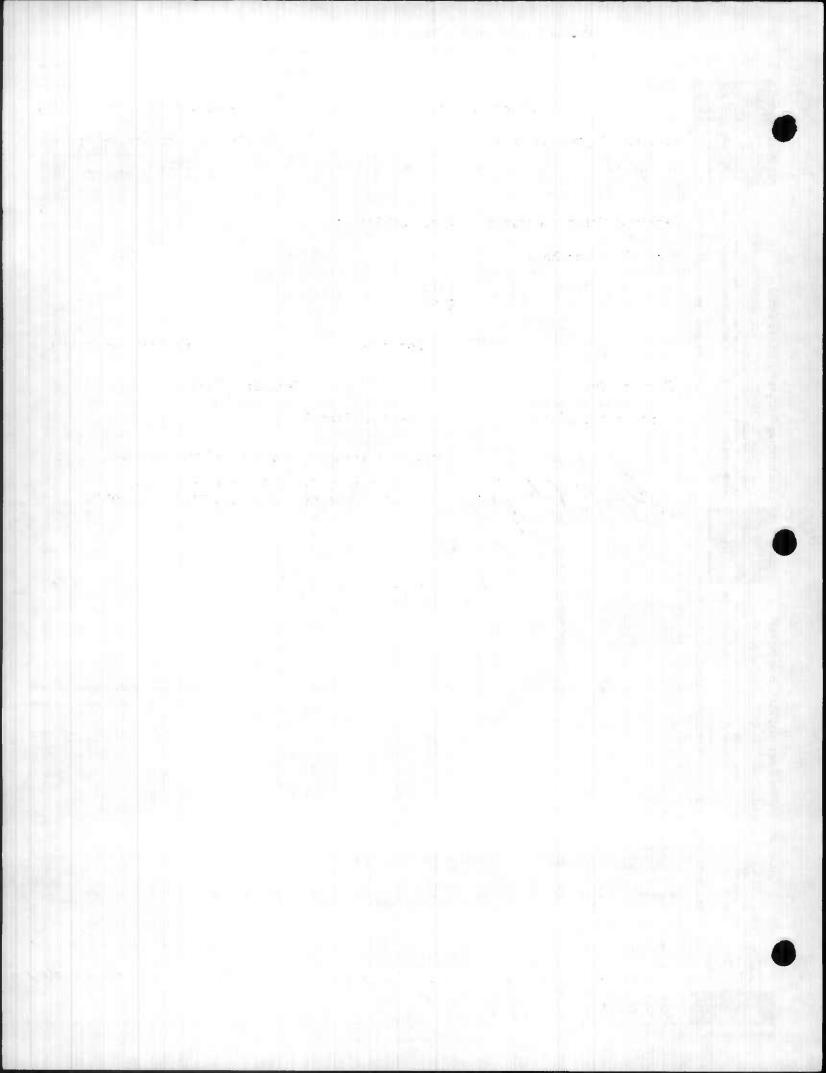
	ed #17, P.G. G.C. 9/2		Cer	tificate of	Death	2. Data of De	Reg. No.	32305 3. Tima of Death	
in al	Franklin E.	Smith				Month Sept.	Day	Year	
er	4a Facility Nama (If not institution, give				4b. City, Town, or I			of Death	
	Prince Georges 5. Social Security Number 6. S	-		If Under 1 Year	Cheverly		P.G.	9. Birthplace (Stata or Foraig	
		M 20 F 79	Yrs.	Months Days	Hours Min.	8. Data of Bir (Month, Da Mar. 1	3, 1921	Country) N. C.	
ŀ	10a. State 10b. County	10c. Cit	y, Town or Loc	cation				10d. Inside City Limit	
	DC.	Wa	shingt	on, D.C.					
	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?	
	4272 East Capito	1 St., N.E.		20019			US		
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 1 Yas 2 □ No If Yas, Giva Year or Datas:	If	Vas Decedent of I Yes, specify Cub	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yas or No o Rican, atc.)		- Amarican Indian, k, Whita, atc.	
	15. Decedent's Ed		16a. Deced	ent's Usual Occur	pation		16b. Kind of Bus		
-	(Specify only highest gra	da completed) College (1-4or 5+)	(Giva I	kind of work done OO NOT use retire	during most of wor	king			
	Lioniana yroddinau y (5 12)		Polic	e Office	r		Fed. Go	vt.	
	17. Father's Name (First, Middle, Last)	741 M	C1				Maiden Sumama	a)	
ŀ	Jimmy Steven		1			Morehe			
	19a. Informant's Name/Relationship (1) Ernestine Tra	nquille / Dau.			St. Apt			Stata, Zip Code) 11212	
ŀ	20a. Mathod of Disposition	20b. F	Place of Dispos	sition (Nama of		Data		City or Town, State	
l	1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemovai Irom Stata		natory or other pla NATIONAL		9/22/00	TRIANGL		
ŀ	21. Signature of Funaral Service Licon			Nama and Addre			Rhines		
	1 (max	CC027	73 30	30 12th	St., N.E.	-	D.C. 200		
minedata causa (rimal disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Dua to (or as a consequence of): a. Dua to (or as a consequence of): Cardiovascular Disease Due to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of): Due to (or as a consequence of):									
	Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	r as a consequ	vence of):				1	
-	Part II. Other significant conditions co	ontributing to death but not ras	ulting in the un	derlying ceusa gi	ven in Part I.	23b. Did	tobacco use con	tribute to the cause of deat	
					7	10	Yee 2□No	3 Probably 4 Number	
Completed by						24a. Was	an autopsy ormed?	24b. Wara eutopsy findings available prior to completion of causa of death?	
L						10	Yas 2∏ No	1 ☐ Yas 2 ☐ No	
l				low	26. Place of Dea	th (Check only	one)		
-	25. Was casa refarred to medical examinar?	Linewitch.		3 DOA	her: 4 Nursing H	oma 5 🗆 Rasi	dance 6 □Otha		
	examinar? \text{\ti}\text{\texi{\text{\texi{\text{\texi\text{\text{\text{\text{\text{\text{\text{\text{\tin}\text{\texi{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\ti}\tint{\text{\text{\text{\texi}\tint{\text{\text{\texi}\text{\ti}\text{\text{\text{\text{\text{\texi}\text{\texit{\text{\t	Hospital: 1 Inpatient 2 1 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Tima of Injury	28c. Inju Wo		28d. Describe	now injury occurre		
	examinar? 1√2 Yas 2 □ No	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Inju Wo M 1	ry at rk? IYes 2 □ No		Street and Numbe	or or Rural Routa Number,	
	examinar? Yas 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Cartifier 1 Certifying Physics 1 Certifying Physics 1 Certifying Physics 1 Certifying Physics 1 Certifying Physics 27. Manner of Death 5 Pending invastigation 6 Could not be detarmined	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At he building, etc. (Specification) 28a. Place of Injury - At he building, etc. (Specification)	28b. Tima of Injury Dime, farm, stre	M 1 cet, factory, office	Yes 2 □ No	28f. Location (City or To	Street and Number wn, Stata) cause(s) and mar	or or Rural Routa Number,	
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State of Maryland / Department of Health and Mental Hygiene

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					CE	entitica	te of	Death			Reg. No.			00	
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Physician			Steve	A. Sur	tees					Month	ber 25	2000	10.1	OPM	
/Medical	4e Fecility Nen	ne (If not institution,			CCCD			4b. City, To	wn, or Lo	cation of Dee		nty of Deeth	10.1	0111	
Examiner		ashington						Fort	Wash	ington	Pri	nce Ge	orge	c	
	5. Social Securi	-	6. Sex	7. Age (In yrs.	lest birthday) If Unde	r 1 Year	If Under							
Funeral Director	216-38		1₽M 2□ F		Yrs.	Months	Deys	Hours	Min.	8. Date of B (Month, D May 16	lay, Year)			e or Foreign	
			Λ	103			l			ray 10	,1737	Hung	ary		
pue *	10a. State	suel Residence of Decedent Da. State 10b. County 10c. City, Town or Location											10d. Inside	City Limits	
deryten f ahow	Manu 1 a	nd Daines	Cooman	F.	mt Man	hinat							1 🗆 Y	es 2 No	
vith the Mer or 28a-fa be notified Director		Maryland Prince George's Fort Washington 10e. Street end Number 10f. Zip Code									ntry?				
be filed within 72 hours after death with the Meryland ntal Hygiene. Id other than "natural", or items 23a or 28a-f ahow event, the Medical Examinat must be notified at Be Completed by Funeral Director		9225 Allentown Road 20744													
r items 23anner must.				andert Ever in I	10 12	Was Door			ain? (Sne	acify Ves or N	O- 14 F	USA Race - Ameri	can Indian		
er de la la la la la la la la la la la la la	11. Meritel Stet		Armed	12. Was Decedent Ever in U,S. Armed Forces?		13. Wes Decedent of Hispenic Origin? (Spilf Yes, specify Cuben, Mexican, Puerto			Rican, etc.)		Bleck, White,				
urs aft	300000	Merried 2 Marrie d 4 □ Divorced	If Yes, o	s 2□No 19 Give	58-	1 🗆 Yes	2 XNo	Specify:			Spe	city: Wh	ite		
hour hour	3 Wildowi			Deles. 19	64	adaetia Her	iol Occur	nation			16h Kind o	f Business/In	duetru		
ed within 72 ho ygiene. Per than *natura ft, fre Wedleat Completed	(5	15. Decedent's Specify only highest		d)	(Giv	edent's Usi e <i>kind</i> of w DO NOT	ork done	during mos	t of worki	ing	16b. Kind o	Dusinessan	dustry		
withir than than the Month	Elementery/S	Secondary (0-12)	College	(1-4or 5+)	_	smith		uj			Federa	al Gov	ernme	ent	
	47 Follows No	12th						40 Mathe	da Nome	/Cinnt Middle					
De data H	_	me (First, Middle, Li	ast)								Middle, Maiden Sumeme)				
2 should be filed within and Mental Hygiene. Is marked other than aurmatic event, the M	Feren	c Toth						En	ilia	Gad	jos				
s 1 and 2 should f Health and Mar item 27 is marke other traumatic		s Name/Relationshi							er or Rure	el Route Num	ber, City or To	wn, Stete, Zij	Code)		
1 end 1 Health em 27 ther tr	Blanca	Surtees/	Wife		Sam	ne as	iten	n 10							
	20a. Method of				Plece of Disp cemetery, cre	osition (Ne ematory or	eme of other ple	ice)		Date	20c. Location	on - City or T	own, State		
0 = - 0		2 ☐ Cremetion 3		m State Ma	ryland	Vete	erans	s Ceme	terv	10/3/2	000 Ch	eltenh	am, MI).	
permit. Pa Departmen Important: any Injury once.		Funeral Service Li		1				ess of Fecili							
Per Per Per Per Per Per Per Per Per Per	100	01	len 1	1	G	George	P.	Kalas	Fun	eral H	lome, P	.A.			
	y	10.1	1)	16	160)xon	Hill	Rd.	Oxon H	[i]1, Mo	1. 207		nata	
	23a. Part1. Wh shocksor	ter the disease, of c heart failure. List o	omplications the	caused the dea	th. Do not er	nter the mo	ide of dyli	ng, such es	cardiec	or respiretory	errest,		Approxin Intervel E Onset er	Between	
Physician				1 . 17	- 1		^					1	Criset er	IO Dee(II	
/Medical	Immediate Cause (Finel disease or condition resulting in deeth) Bue to (or es e consequence of): Concer Cancer Due to (or es e consequence of): Due to (or es e consequence of):									1	6	M.			
Examiner	I resulting in dee	oth)	0	Due to (or es e conse	equence of):			. ,					
executed in and instruction and Examiner				-	Hen	atic	Eu	enl	les	rth			5	0.	
death certificate be executed e attending physician and of or use as the bunal-trensit ician/Medical Examir	Sequentially lis	t conditions.	b	Due to (or es e conse	equence of):			-					
an an an an an an an an an an an an an a	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events Due to (or es e consequence of): Due to (or as e consequence of):														
ertificate be ling physicie e as the bu	Ceuse (Diseas that initieted ev	e or Injury ents	c	Due to (or as e conse	equence of	:								
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at the death c d by the attence etached for us Physician	Part II Other el	anificant condition	e contributing to	entributing to deeth but not resulting in the underlying cause given in Pert I.						23b. Did tobacco use contribute to the cause of deat				se of death'	
ras that the designed by the a libe detached it	raitii. Other si	grimeant condition	e contributing to	b deeth but not resulting in the underlying cause given in Perci.						1 Yee .2 No 3 Probably 4 Unknow					
ed bede deta											100 .201	0 00110	, babiy	- OHAHOW	
requires that the seen signed by the hould be detache etect by Physe										24e. We	s en eutopsy	24b. W	/ere eutop:	sy findings	
been s should										per	formed?	9'	veilable pri	or to	
2 2 S												of	death?		
The la page page										1 🗆	Yes 20N	0 1	☐ Yes 2	2□ No	
ystclan: The secreticate director, pag		e referred to medical	26. Plece of Deeth (Check only one)												
hysici nis ce il direc	examiner?	21X No	Hospital:							me 5 Re	sidence 6 🗆	Other (Speci	ity)		
4 ta	27. Manner of E			te of Injury	28b. Time		28c. Inju Wo	ry et	T	28d. Describe	e how injury or	curred			
After fune fune	1 Accide	5 Pending Investiga		onth, Dey Year)	Injury	М		Yes 2	No						
PE - =		6 ☐ Could no	ot be	ice of Injury - Ath	ome, farm, s	street, fecto	rv. office	410		28f. Location	(Street end N	um <i>ber</i> or Rui	ral Route A	lumber,	
death death ctor: A y tha f	3 Sulcide	ide determin	bui	Iding, etc. (Spec	ify)					City or T	own, Stete)				
or Attending Physician: eftar death. Director: Atter this certific in by tha funeral director,	3 ☐ Sulcide 4 ☐ Homic			ha hast of my kn	sudadas dos	th occurre	d at the ti	imo dete er	nd place	and due to th	o cauca(c) and	d manner es	eteted		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 21, 2000 10:35Pm **Physician** Rosa Shaffer /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Name (If not institution, give street end number) Examiner Lanham If Undar 24 Hrs. Doctors Hospital, Lanham Prince George's 7. Aga (In yrs. lest birthday) If Under 1 Year 8. Date of Birth (Month, Dev. Year) 9. Birthplece (State or Foreign Country) 1□M 2♥F Months Days Hours Min. 310-32-8249 67 Yrs. **Director** March 7,1933 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Insida City Limits 1 ☐ Yes 2 No Prince George's Lanham Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 9407 Fontana Drive Funeral 20706 U.S.A. 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - Amarican Indien, Bleck, White, etc. 1 Yes 27 No If Yes, Give Year or Detas: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3√ Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th Food Service Waitress 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be os 1 and 2 should b of Health and Ments I hem 27 is merited Clatterbuck Mildred Wood 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 9407 Fontana Drive Lanham, Maryland 20706 Deborah Shaffer (Daughter) 20b. Place of Disposition (Name of cemetery, cremetery or other place) Sept. 27,2000 20a, Method of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cremetion 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland State Veterans Cem. Cheltenham, Maryland 22. Name and Address of Fecility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 attee 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** 1 Hour /Medical Immediate Cause (Finel disaese or condition resulting in death) Acute Myocardial Infanction Examiner Due to (or as a consequence of): Examine Diabeter Mellitus Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Physician/Medical Due to (or es a consequance of): Part fl. Other significant conditions contributing to death but not rasulting in tha undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings 24a. Wes an autopsy performed? aveileble prior to completion of cause of death? N/A2□ No 1 ☐ Yes 2 No 1 Yes 25. Wes case referred to medical axaminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Certification: To

Box 68760. P.O. Records.

of Vital or Attending Physician: Division after death. Director: Af To the Hospital of within 24 hours a To the Funeral D completely filled



MichAR BERAND 31. Dete filed (Month, Dey, Year) SEP 2 9 2000

27. Manner of Death

1 ANaturel

2 Accident 3 ☐ Suicide

4 Homicide

29b. Signature and title of certifier

29e. Cartifier (Check only one) 5 Pending

investigation

6 Could not be determined

29c. Licansa number 026287

28c. Injury et Work?

1 Yes 2 No

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the causa(s) end menner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

28d. Describe how injury occurred

College Park mi)

30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print)

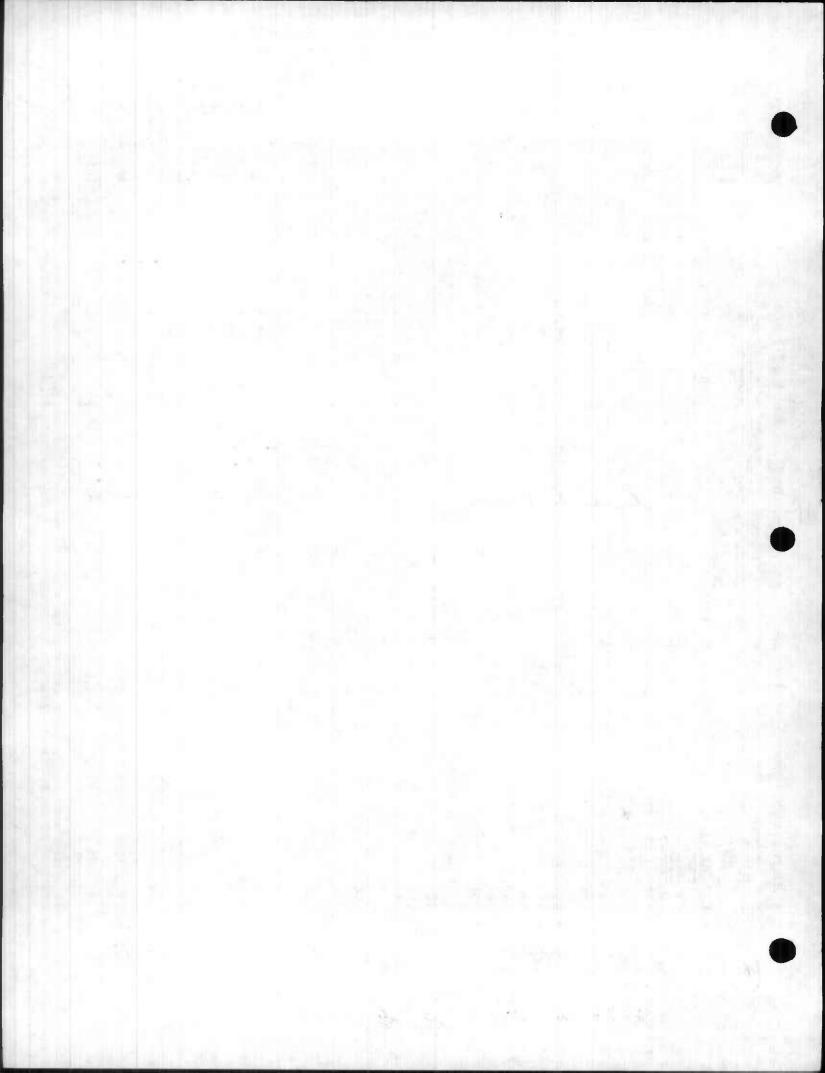
7305 Balt Ave

22. Registrer's Signeture

DHMH 16 Rev 6/95

28b. Time of

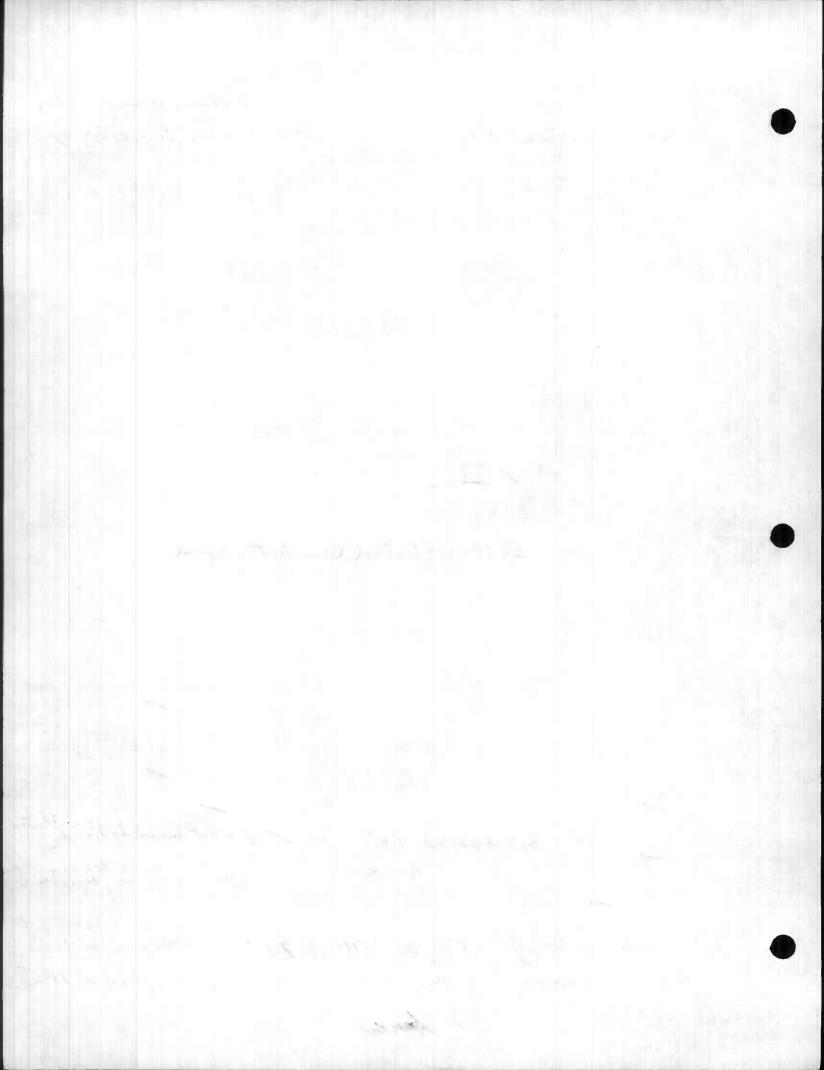
28e. Plece of fnjury - At home, farm, street, fectory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Day Year **Physician** September 21, 2000 JACK RAY SAMPLE 0730 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number 4c. County of Death Examiner grew Mar/horo 16005 Marksoro PRINCE 6 Euroses 8. Data of Birth (Month, Day, If Undar 24 Hrs. If Under 1 Year 5. Social Security Number Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Days Months Hours 1 MM 2□ F MONTANA Yrs. 04/04/1948 52 Director 240-84-3037 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits ral', or items 23s or 28s-f show Examiner must be notified at 1 Nes 2 No PRINCE GEORGES UPPER MARLBORO 10e. Street and Number 10a. Citizen of Whet Country? 10f. Zip Code 급 16005 MARLBORO PIKE 20772 U.S.A. Funeral 12. Was Decedant Ever in U.S. Apped Forcas? 1 △ Yas 2 □ No If Yas, Give Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, White, etc. 11. Marital Status 14. Race filed within 72 hours after 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 Yas 2 No Specify. Specify: à 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) 12 PURCHASING AGENT BUILDING SUPPLY 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) . Pages 1 and 2 should be fit ment of Health and Mental Hant: If item 27 is marked oth lury or other traumatic even Be ALEXANDER SAMPLE BETTY BAKER 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) ROBERT SAMPLE/SON 2702 KIRK LN. BOWIE, MD. 20715 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Removal from Stata permit. Page Department of Important: If any Injury or once. 9/26/2000 CHELTENHAM, 4 ☐ Donation 5 ☐ Othar (Specify) VET. CEMETERY 21. Signature of Funaral Sarvica Licansee 22. Nama and Addrass of Facility BEALL FUNERAL HOME KYLE SIMONS M01206 6512 N.W. CRAIN HWY. BOWIE, MD. 20715 Approximata tntarval Between Onset and Death 23a. Part1. Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disaasa or condition rasulting in death) /Medical Eunshot wound Examiner Dua to (or as a consequance of): Physician/Medical Examiner that the death certificate be axecuted Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): physician the buria Box 68760. Dua to (or as a consequence of): 950 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 → No 3 | Probably 4 | Unknown Records. þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 1 Yas 2 No 1 Yas 2 No of Vital after death.

Director: After this certifications Be 25. Was casa rafarred to medical 26. Place of Death (Check only ona) axaminer? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Hasidanca 8 Other (Specify) Certification: To 28d. Dascribe how injury occurred Self-inticled 27. Mannar of Death 28b. Tima of Division 5 Pending invastigation gunshat wound to head 1 Netural September 21,2000 7.30M 1 Yas 2 No 2 Accident 3 Suicide 6 Could not be 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide home ygger Marlboro 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. To the Hospital
within 24 hours at to the Funeral I edical 29a. Certifier 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signatura and fittle of certifian 00 170055 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) Hos 3001 vesta 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State SEP 2 5 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** JACQUELINE R. September SIMMONS 16/0 24 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 2728 Lorring Drive rovestville 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2₺ F 238-96-6010 Yrs. Director August 10,1958 North Carolina Usual Rasidence of Decedant 10a. Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits item 27 is marked other than "natural", or hema 23a or 28a-f show other treumatic event, the Medical Examinal must be notified at tyExyes 2 □ No Directo Maryland Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 2728 Lorring Drive, #204 20747 U.S.A. Funeral death 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No 14. Race - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 Specify: Black If Yas, Giva Yaar or Datas: 1 Yas 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health end Mentel Hygiene. Important: if item 27 is marked other than "na eny injury or other treumatic event, the Wender page. (Give kind of work done during most of working life. DO NOT use retired) Elamentary/Secondary (0-12) College (1-4or 5+) Housewife Private 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Willie Lee Haskins Lula Russell 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Haskins/Son 2728 Lorring Dr., #204, Forestville, MD 20747 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☒ Removal from Stata Church Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) Manson, N.C. 21. Signature of Funaral Sarvica Licensee J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 Vancu ercen 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Condisursentar Disesse Examiner Dua to (or as a consequence of) Examiner attending physician and for use as the buriel-transit that the death certificate be executed Sequantially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detact 3. Probably 4 Unknown 1 ☐ Yes 2 ☐ No Records. à 24b. Were autopsy findings available prior to complation of causa of daath? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No certificate of Vital 25. Was casa refarred to medical Be 26. Place of Death (Check only one) axaminer? Other: 4 ☐ Nursing Homa 5 ☐ Hasidence 6 ☐ Othar (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? at or Attending P s after death. If Director: After ed in by the tuner Division 5 Pending invastigation 1 Natural 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide e Hospital o 24 hours at a Funeral D letaly filled i Medical 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 22 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. To the To the F 29c. License number 29b. Signatura and titla of certifier 29d, Data signed (Month, Day, Year) 10 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Alvadon Hospita Cheverly 3001 31. Data filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 6 2000 Registrar

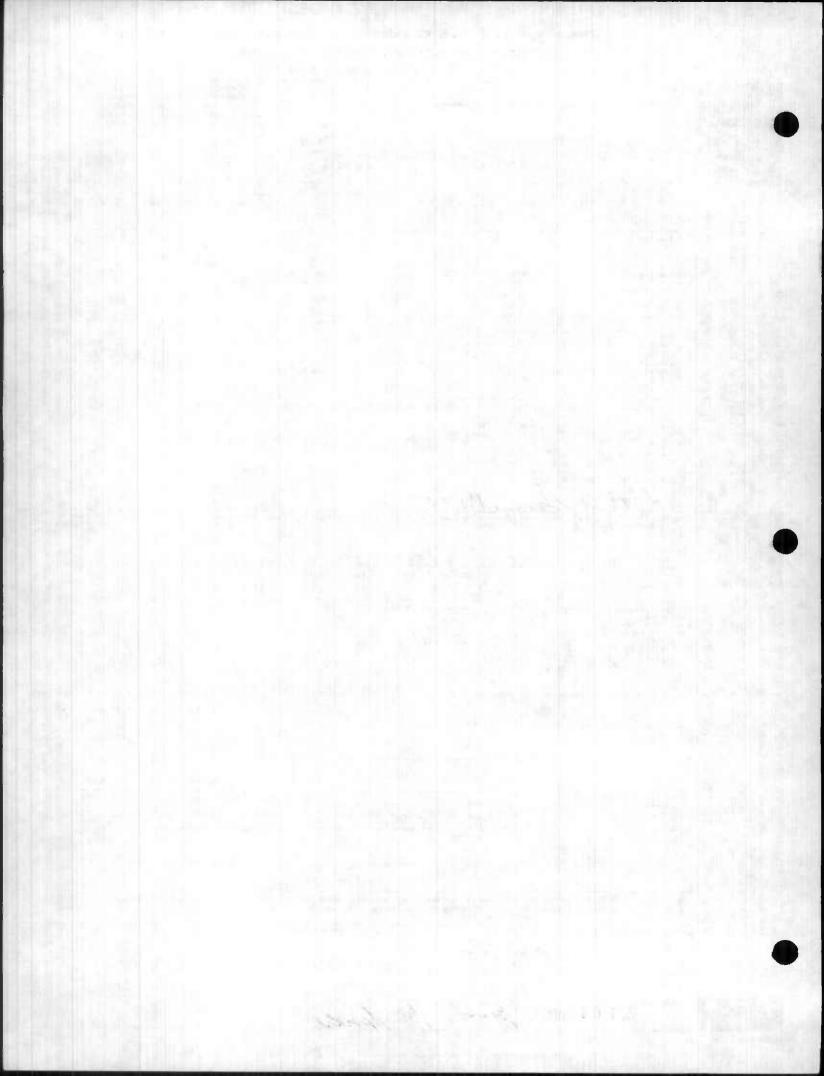
State of Maryland / Department of Health and Mental Hygiene

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	Examine	_	4a Facility Nama (If not institution, giv	a street and num	iber)			4b. City,	Town, or Lo	ocation of Dea	th 4c. County	of Death		71		
			3904 Canterbury Wa	ay					ple H		Prince					
	Funeral Director		311-30-1023	Sex □M 2□F	7. Aga (In yrs. 72	last birthday) Yrs.	If Under 1 Y Months Do	ear If Und ays Hour	er 24 Hrs. Min.	8. Data of Bi (Month, D Sept.	rth ay, Year) 13,1928	9. Birthr Cour Wash	placa (Stata or intry)	Foreign DC		
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d 21215-0020 filed within 72 hours after death with the Marylend	the N	by Funeral Direct	lect	ecto	10a. Street and Number			omp.cc .	10f. Zip Co	da			10g. Citizan of V	What Cour		71
	23e or		3904 Canterbury	Way	+ 1		2074	8			USA					
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0-0	natural,	9	15. Decedent's Ed			16a. Deced	ant's Usual O	ccupation	and advisord		16b. Kind of Bu	sinass/In	dustry			
21215-0020	filed within 7 Hygiene. ther then "n	Completed	(Specify only highast gra Elementary/Secondary (0-12) 12th	College (1-	4or 5+)	lifa. L	ONOT usa re	etired)	OST OF WORK	mg	Banki	ng				
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Maryland	0 = 0 = 0	10 00	Pasquale A. Magg:	io				Ma	ary M.	. Kines						
ary	should bent marked	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (St	reet and Nur	nber or Run	al Routa Numi	per, City or Town,	Steta, Zip	Coda)			
	DENE	-	Mary K. Brotherton	n/Daught	er	4107	Rivery	iew C	. Dur	nkirk.	Md. 2075	4				
Baltimore,	ーゴミラ		20a. Mathod of Disposition		20b. F	lace of Disposematery, cram	sition (Name o	of		Date	20c. Location -		wn, State			
9	00		1 ☐ Buriat 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		tata	shingto			1/27/2	2000	Suitlan	d M	d			
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ä	permit. Departrimportu		Id well	1/11		Geo	orge P.	Kalas	Fune	eral Ho	me, P.A.					
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	that ded by dete							HILL		1/2	Yes 2 No	3 Pro	bably 4 □ U	nknown		
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3ec	has b	2				The state of							death?			
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/it	Physician: The lav this certificate has ral director, page 2	0	25. Was cesa rafarred to medical axaminer?	Lle soltet:					ace of Deat	h (Check only	ona)					
ot	hy his	- -	1 ☐ Yas 2 ☐ No	1		ER/Outpatien					idance 6 Oth		fy)			
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Division	tal or Attanding P rs after death. al Diractor: After t led in by the funera		3 ☐ Suicide 6 ☐ Could not be determined 28a. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify)								28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)					
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	To the Hospital or A within 24 hours after To the Funeral Dira completely filled in b		29e. Certifier 1. ☐ Certifying Ph (Check only one) 2 ☐ Medicat Exam		sis of examine											
	within 7 to the comple	E	29b. Signature and title of certifier	CI	1.0	11.1	29c. Li	cense numb	2 >		29d. Data signer	d (Month,	Day, Year)			
	6		Muy 7.	870	ver,	(W)		2140			9-2	5-	2000			
	(In)	-	30. Nama and address of person who	complated cause	of death (Item	23a) (Type	Print) 4 -		11	11				. 1		
	(10)		30. Nama and address of person who	LUER	MS	110 H	0501	ALA	10, 1	URINC.	t FREO	F151	015	3		
	State		31. Data filed (Month, Day, Year)		gistrar's Signa								6 10			
	Registrar		SEP 2 6 2000	50	sation	6.	long w	,								

CS Amended Item#1 perMEOG789 11/6/2000 EW Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene HARVEY SHIVERS Certificate of Death 23a, 27, G788 10/16/00 vf amend item 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Harvey Tyrone Shivers. Jr. SEPTEMBER 27, 2000 14:40 PM /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 615 63rd PLACE PRINCE GEORGE'S SEAT PLEASANT If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 12 M 2□F 40 Yrs. Director 579-90-5393 18, 1959 Rockville, Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Prince George's Seat Pleasant Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 'natural', or flams 23s or odical Examiner must be 615 63rd Place 20743 United States Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. Specify: Black à 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondery (0-12) Cotlege (1-4or 5+) 12 Landscaper Private 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Pages 1 and 2 should be and Mental Harvey Shivers Gladys Feldor 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) important if hen 27 is m any injury or other 2008. 63rd Place Seat Pleasant, Md. Harvey Shivers/ Father 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Beltsville Md. 10/6/00 Chesapeake Crem. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Alexander S. Pope Funeral Homes MO1085 5538 Marlboro Pike/Forestville, Md. 20747 23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate intervet Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or es e consequence of): Physician/Medical Examine The law requires that the death certificate be axecuted Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were eutopsy findings evailable prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? 2 No 1 Yes 2□ No or Attanding Physician: 25. Wes cese reterred to medicel exeminer? 26. Piece of Deeth (Check only one) Be Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE XXYes 2□ No OL this 28e. Dete of Injury (Month, Day Year) Certification: 27. Menner of Death 28c. Injury et Work? 28d. Describe how injury occurred 1 DeNeturet 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: A 2 Accident 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certific SEPTEMBER 28, 2000 O.C.M.E. 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) M. Mid 111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Signeture 2000 Registrar DHMH 16 Rev 6/95

ORIGINAL



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amend	item	23a,27,	per	me	G788	10/16/00	yf

RUBY JVW	SMITH	Ple 23a,27, per me G788			nd / Depa		Health a					le.	32312	
	amend Item				Cel	lilicate o	Deam			Reg. No.				
	Physician	Decedent's Name (First, Mid	die, Last)						2. Dete of Deeth Month Day Yea			Year	3. Time of Death	
	/Medical	Ruby Sm	ith										12:35 A.M	
	Examiner	4a Facility Nema (If not instituti	on, giva street and nur	n <i>ber</i>)			4b. City, Tow	n, or Lo	cation of Dea	ath 4c.	County o	f Deeth		
		14800 4th S	L			PRI	NCE	GEORGE'S						
- 11	Funeral	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthdey) If Under 1 Yaar If Un							9. Birthp	leca (Stete or Foreign	
	Director	247-02-7124	1□ M 22XF	1 M 20%F		Months Dey	ys Hours	rs Min. (M					ter, S.C.	
D. C.		Usuet Residence of Decedent							oury r	, 1))	2	Dunit		
	Man Man	10a. Stete 10b. Count	•		ity, Town or Lo	cation				63.1		1	0d. Inside City Limits	
	Man Lah	Maryland Prince George's Laurel									Y	1 Yes 2 □ No		
	ifter death with the Maryland of thems 23s or 28s-f show viring the motified at Funeral Director	10e. Street and Number		10a. Citi	zen of WI	het Cour	ntry?							
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002	ours a	3 ☑ Widowed 4 □ Divorce	Year or Da							ороспу.	DIUCK			
5-6	filed within 72 hours after Hygiene. They free than "natural", or the infer than "the Made at the mina and th	15. Decede	nt's Education ast grade completed)		16a. Deced	lent's Usuel Occ	ina	16b. Kir	nd of Bus	iness/In	dustry			
7	nid and	Elementery/Secondery (0-12)		life. I	kind of work do OO NOT use ret	9		NT /						
Baitimore. Maryland 21215-0020	d wil	12			Di	sabled					N/A	A		
7	be filed within 72 ho tal Hygiene. I other than "natura went, tra Medical. Be Completed	17. Father's Neme (First, Middle	, Last)		11		18. Mother	's Name	(First, Middl	le, Meiden	Sumeme)		
a	id by keed by id b													
2	shound M	19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)										Code)		
2	d 2 Than	Dontez Smith / Son 314 #C Mountain Ridge CT. Glen Burnie, Md.												
d	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, trail and the statement of the traumatic event.	20a Method of Disposition 20b Place of Disposition (Name of								Date 20c. Location - City or Town, Stata				
ō	or or	to Burial 2 ☐ Cremetion	metory or other place)											
	Pa ment: ury										0/10/00 Landover, Md.			
0	mit popular in John	21. Signature of Funerel Service	21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Alexander S. Pope								e Funeral Homes			
^	22528	Stath a. Have MOIOR 5538 Marlboro Pike/Fo												
de		23a. Part1. Enter the diseens	or complications that co	ausad the dee							10,	ild.	Approximata	
U	Dhuriaian	shock, or heart feilure. Li	or complications that caused the death. Do not enter the mode of dying, such as card int only one cause on each line.						Inter				Intervel Between Onset end Death	
	Physician / /Medical	Immediate Cause (Finel									1			
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		uenca of):												
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Box	attendin for use		d											
	nat the death certificate be d by the attending physici letached for use as the bu Physician/Medical	Pert II. Other significant condit	lone contributing to de	ath but not re-	sulting In the u	derlying cause	given in Pert 1		23h DI	d tobacco	use conf	tribute to	o the cause of death?	
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ital Records.	The law requires that the death certificate be also has been signed by the attending physicia page 2 should be detached for use as the but Completed by Physician/Medical		100						249 144	es an autop	neu	24b. W	ere autopsy findings	
0	been s should								per per	formed?	Jay	av	ailabla prior to	
ec o	has b						of de				death?			
<u> </u>	The law ate has be page 2 s					1 ⊠Yes 2 □ No 1 ⊠Yas 2 □					XYas 2□ No			
0	den: The	25. Wes case referred to medical axaminer?								eeth (Check only one)				
-	. A Y	r engarmment r												

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this ce compietely filled in by the funeral directors. Medical Certification:

Hospital: 1 | Inpetient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 Nother (Specify) | SCENE 1X Yas 2□ No 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 1 X Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner stated.

29b. Signeture end title of cartifier

29c. License number O.C.M.E. 29d. Dete signed (Month, Dey, Year) OCTOBER 04,2000

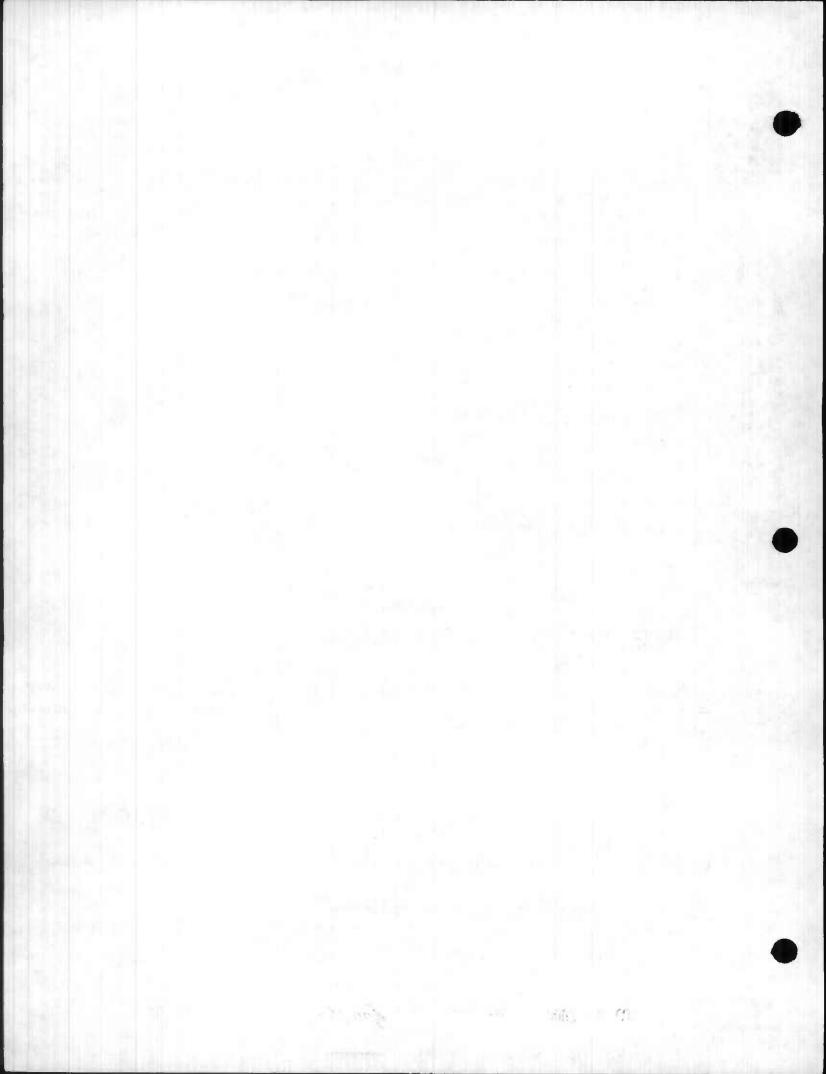
30 Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Dete filed (Month, Day, Year)

OCT 0 5 2000

32 Registrar's Signatura



Amended Item #3, Per Phy., 09/28/2000, Carroll County, cew Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Deeth 12:45pm **Physician** Month MARY D. SMITH SEPTEMBER 22,2000 /Medical 4a. Facility Name (If not institution, give street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON BALTIMORE MEDICAL CENTER Photos 1 Year If Under 24 Hrs. GREATER BALTIMORE 8. Date of Birth Aug 5, 1920 7. Age (In yr. 80 9. Birthpiaca (Stete or Foreign **Funeral** 235-12-1838 1□ M 2∏ F Days West Virginia Vrs Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23e or 28a-f show Carroll Eldersburg Director 1 Yes No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23e 1663 Gemini Drive 21784 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No Specify: Specify: White by 3℃ Widowed 4 Divorced 7 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade com 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bualness/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Clarence John Davis Beatrice Mahoney 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 is other tre Mrs. Mary S. Cremen (Daughter) 6827 Ridge Road Eldersburg, MD 21784 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from Stata 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Locetion - City or Town, State = 0 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 9/26/00 Baltimore, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Interval Between Onset and Death **Physician** Immediate Cause (Finel disaese or condition resulting In deeth) /Medical Examine Dua to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediale ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last and Physician/Medicai 88 Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by Pe ed 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred After 5 Pending investigation Natural 24 hours efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Straet and Number or Rural Route Number, City or Town, State) in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as atlated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the H within 24 To the F 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Yeer) D 26250 Aejitember 22, 2000 Do, MD 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) So NORTH CHARLES ST, BALTO, MD. 21204 MATILDA 6701 31. Dete filed (Month, Dey, Yeer) 32. Registrar's Signature SEP 28 2000 Registrar

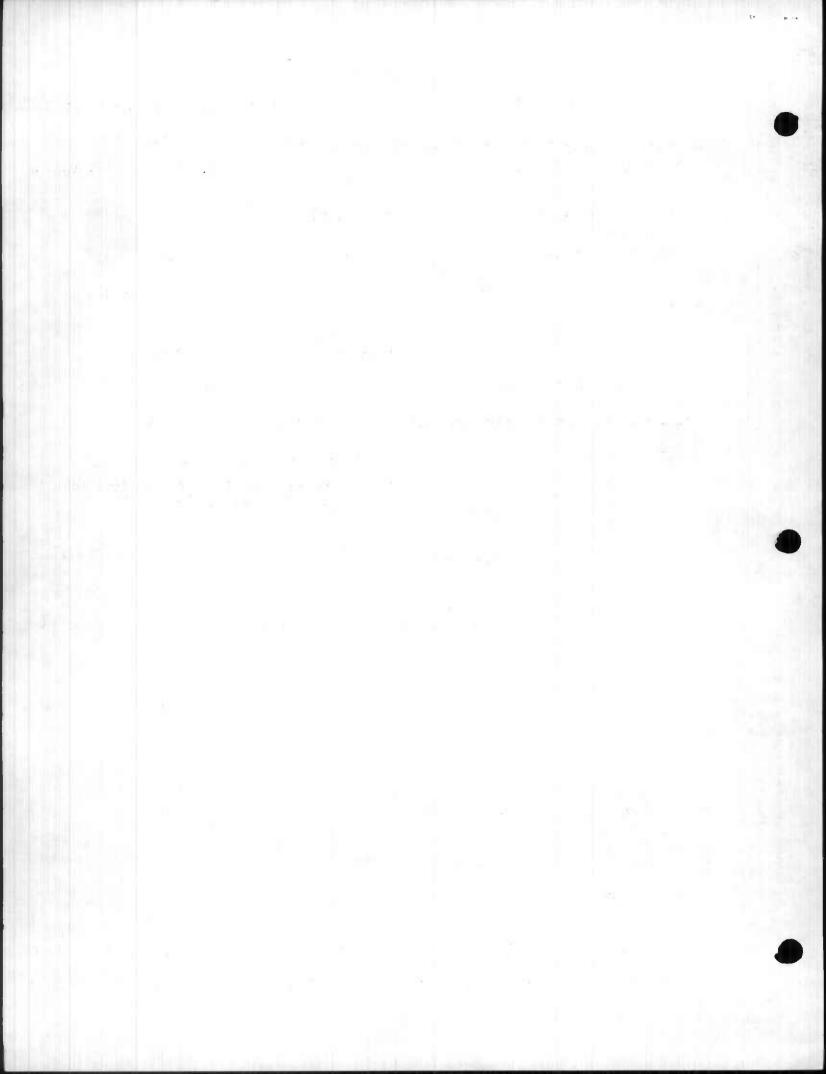
Baltimore, Maryland 21215-0020

Box 68760.

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Records,

Division of Vital



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death September 25, 2000 **Physician** illie Smith /Medical 4s Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Northwest Hospital Center Randallstown Baltimore If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthplace (Steta or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Hours 218-01-0442 78 Vrs. Apr. 1, 1922 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits 23a or 28a-f show 1 ☐ Yes 2X No Directo Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7B Woodbriar Court 21244 U.S.A. Funeral Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. or Harra permit. Pages 1 and 2 about be fired within 72 hours after. Department of Health and Mental Hygiene.

Bry Injury or other. 1 Yes 2 No
If Yes, Give
Year or Datas: 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: Black by 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Housekeeper Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 88 Albert Brown 2 Maggie Robinson 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Martin King (Son) 7B Woodbriar Court Baltimore, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Steta 20e. Method of Disposition Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removet from State 9/29/00 Baltimore, MD Western Star Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service License 22. Name and Address of Fecility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Bruan 2. Alaides Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical tmmediate Cause (Finel disease or condition resulting in death) Examiner The law requires that the daeth certificata be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bronary P.O. Box 68760. Physician/Medical Dua to (or as e consequence of) tha USB 85 signed by the at d be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 1 ☐ Unknown Division of Vital Records, þ 24b. Were eutopsy findings available prior to complation of causa of death? Completed 24a. Was en autopsy performed? hes 1 ☐ Yes 2 ☐ No this certificate 1 ☐ Yes 25. Was case referred to medical examiner?

1 Yes 2 No Attanding Physician: funeral director. Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After Netural 5 Pending To the Hospital or Attandit within 24 hours after death.
To the Funeral Director: At completely filled in by the fu death. 1 TYes 2 TNo 2 Accident investigetion 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.

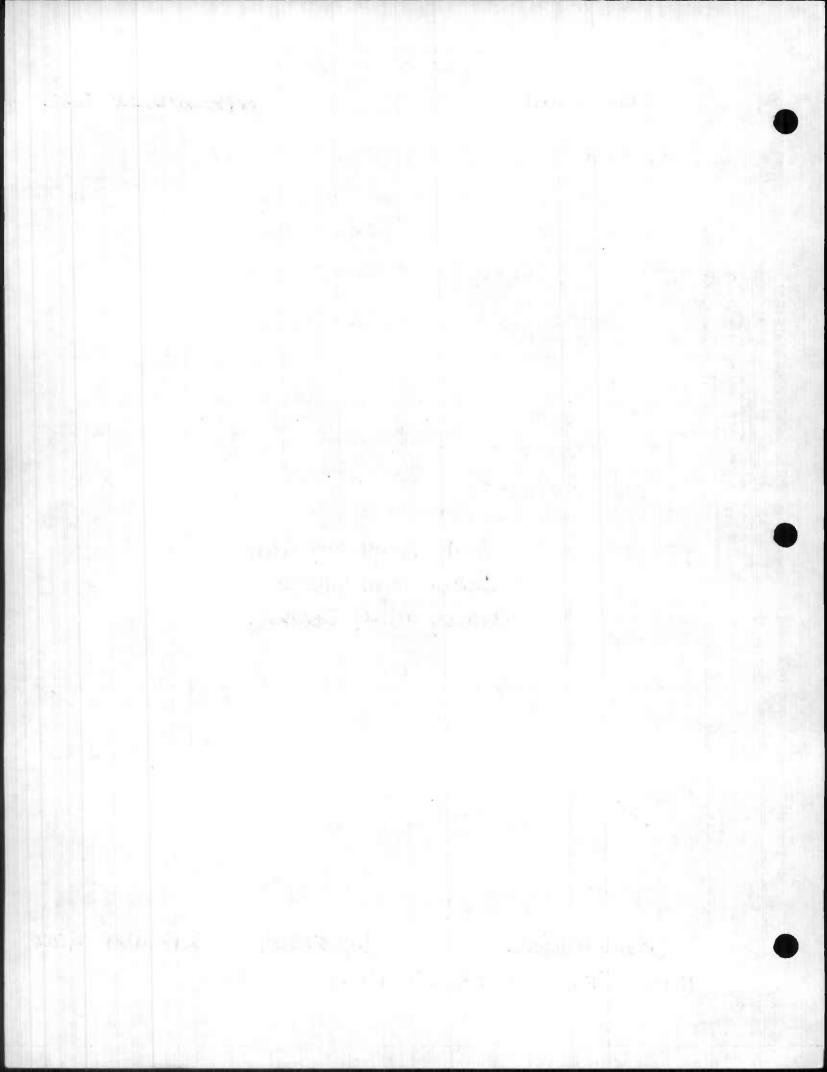
Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated. 29a. Certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) Court Road 540 2 andalls fown MD 21133 00 Date filed (Month, Dey, Year) 32. Registrar's Signeture State 28

DHMH 16 Rev 6/95

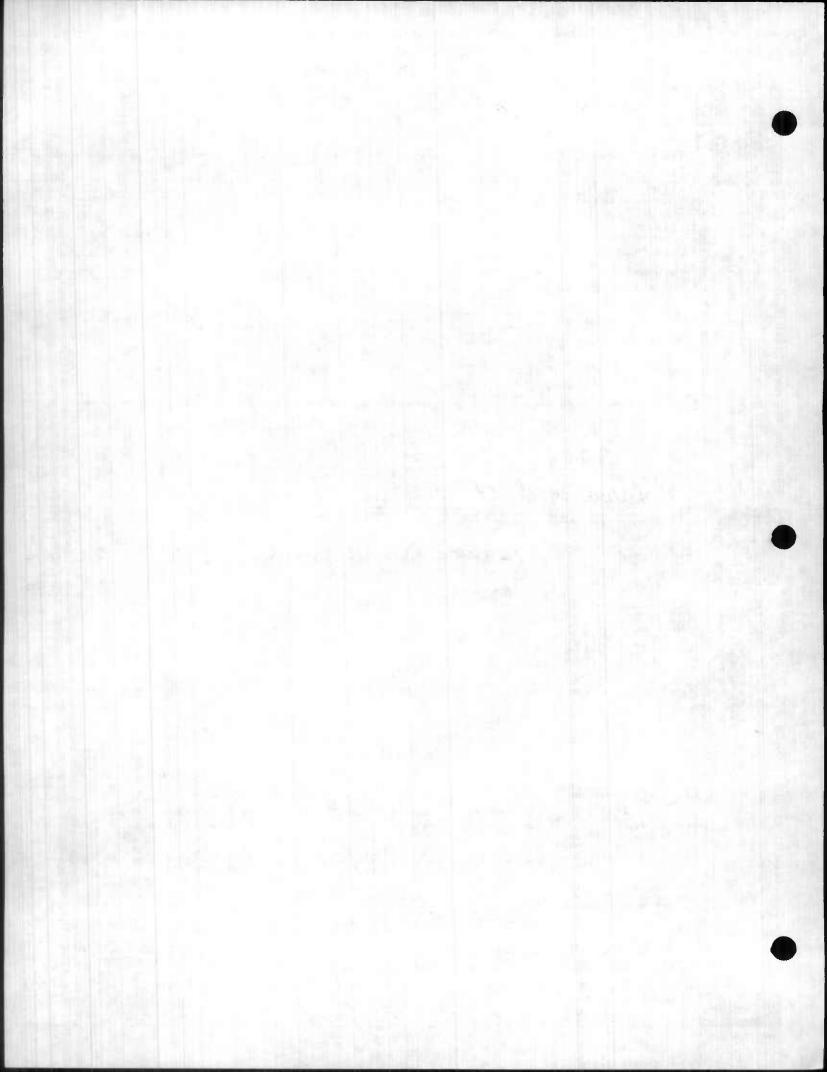
Registrar

2000



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Director Usuel Residence of Decedent 215-01-4750 XD M 2D F 83 Yrs. Months Deys Hours Min. April 1917 Mar. Win. April 1917 Mar. Wall Mar. Was Min. April 1917 Mar. Was Mar. Was Min. April 1917 M	County Inplace (State or Foreign Yand 10d. Insida City Limits 1 Yes 2 No Intry? Ican Indian, , etc.
William Alvin Super Sept. 27, 2000	County Inplace (State or Foreign Yand 10d. Insida City Limits 1 Yes 2 No Intry? Ican Indian, , etc.
Examiner 4a Facility Name (If not institution, give street and number) Carroll County General Hospital Funeral Director 5. Social Security Number 215-01-4750 Westminster 6. Sex X M 2 F 83 Yrs. 7. Age (In yrs. last birthdey) Yrs. Wonths Deys Hours Min. April 1917 Mark Mark Mark Mark Mark Mark Mark Mar	County Inplace (State or Foreign Yand 10d. Insida City Limits 1 Yes 2 No Intry? Ican Indian, , etc.
Funeral Director 5. Social Security Number 6. Sex X M 2 F 83 Yrs. 6. Sex X M 2 F 83 Yrs. 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth April 1917 Man. A	place (State or Foreign Pland 10d. Insida City Limits 1 □ Yes 2 No untry? ican Indian, , etc.
Usual Residence of Decedent 100 State 110 City Town or Location	10d. Insida City Limits 1 □ Yes 2 No untry? ican Indian, , etc.
10g State 10h County 10c City Town or Location	1 □ Yes 2 No untry? icen Indian, , etc.
MD Carroll County Sykesville 10a Street and Number 10d Zin Code 10c Citizen of What County	intry? ican Indian, , etc.
To Citizen of What Court 10g Citizen of What	ican Indian, , etc.
922 Buckhorn Road 21784 U.S.A.	, etc.
Armed Porces? If Yes, speciny Cuben, Mexican, Puerio Hican, etc.) Bleck, White,	
15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/In	ndustry
Elementary/Secondary (0-12) College (1-4or 5+)	
Elementary/Secondary (0-12) College (1-4or 5+) 12 Newspaper Pressman Printing 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme)	
Specify: White Spec	
19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip.	ip Code)
Mrs. Dorothy M. Super (Wile) 922 Bucknorn Road Sykesville, MD 21/84	
20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State 1 Donetion 5 Other (Specify) 20b. Place of Disposition (Nema of cametary, cremetary, or other place) Crestlawn Memorial Gardens 9/30/00 Marriotts	
21. Signeture of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA (Box Sykesville, MD 21784 (410)-795-1400	195)
23a. Part1. Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.	Approximete
Physician Physician	Intervel Between Onset and Death
/Medical Immediate Ceuse (Final METASTATIC DECETATE CANCER	> 1 YEAD
Examiner resulting in deeth) a. Due to (or es a consequenca of):	> 3 MONTHE
ANEMIA	> 3 MONTHS
Sequantially list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initialed events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequenca of): Due to (or as a consequenca of):	
d	to the cause of death?
0 5 5 7 1 1 1 Ves 2 1 No. 3 1 Pro	obably 4 thinknown
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29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as a control of the course of axamination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause (s) and menner as a control of the course of th	stated. to the cause(s)
29c. License number 29d. Date signed (Month,	n, Dey, Year)
I talled A Tures D20806 September 2	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRICK A TORNES, ND SUITE 102, LOGO LIBORTURD ELDERSBURG	
State Registrar SEP 2 8 2000 32. Registrer's Signeture	



• •	ryland / Department of Health and		
	Certificate of Death	Reg. No.	02010
Decedent's Neme (First, Middle, Last)		2. Dete of Death	3. Time of Dea

Hours

Physician /Medical Examiner

Edna Mae Shipley 4e Facility Neme (If not institution, give street end number)

September 22 2000 8:00AM 4b. City, Town, or Location of Death 4c. County of Death

310 Main St. 5. Social Security Number

New Windsor If Under 24 Hrs.

Min

Carroll

Funeral Director

28a-f show

Directo

Funeral

þ

Completed

Pages 1 and 2 should be filed within 72 hours after death with the Maryla neat of Health and Mental Hyglene.
ant: If Hem 27 is marked other than "natural", or Hems 23a or 28af ehou ury or other theumatic event, in "social Exercises in the Parks that

permit. Pages Department of Important: If It any injury or o

Physician

/Medical Examiner

sician and burial-transit

attanding physician for use as the buria

sata has been sig page 2 should b

certificata has

After this

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

the funeral

88 020

The law requires that the death certificate be asscuted

Box 68760.

P.O.

Division of Vital Records.

Physicien:

Physician/Medical Examiner

by

Be Completed

Medical Certification: To

Baltimore, Maryland 21215-0020

215-32-7920 Usuel Residence of Decedent Maryland

10c. City. Town or Location

Yrs.

7. Age (In yrs. lest birthday)

82

8. Date of Birth (Month, Dey, Year) Apr. 30, 19

 Birthplace (Stete or Foreign Country) Maryland

10a. Stete 10b. County

Carroll

New Windsor

10f. Zip Code

Months

If Under 1 Yeer

Deys

10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 310 Main St.

11 Meritel Status

1 M 2 X F

21776

U.S.A. Black, White, etc.

10g. Citizen of Whet Country?

1 ☐ Never Merried 2 ☐ Merried 3 ☑ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

White Specify:

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12)

College (1-4or 5+)

18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) Supervisor of quality control

16b. Kind of Business/Industry importer & distributor internat'l. handcrafts

17. Father's Neme (First, Middle, Last)

John Sier

18. Mother's Neme (First, Middle, Maiden Sumeme) Janie V. Burke

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

New Windsor, MD 21776

19a. Informent's Neme/Reletionship (Type, Print) Anna M. Myers/ daughter

301 Main St. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece)

Dete

20c. Location - City or Town, Stete

20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify)

Methodist Cemetery

9/25/00 Taylorsville, MD 22. Name end Address of Fecility Hartzler Funeral Home

21. Signature of Funeral Service Licensee

310 Church St., New Windsor, MD 21776

atharine (23e. Peril. Enter the disease, or complications that callsed the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on an hilling.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Final disease or condition resulting in deeth)

congestive heart failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

_		_	_	_	_		
	Due	to	(or	es	е	consequence	of)

Due to (or as e consequence of)

Pert ii. Other significant conditions	contributing to	death but not	resulting in the ur	nderlying ceuse	e given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed?

26. Piece of Deeth (Check only one)

1 ☐ Yes 2 No

1 ☐ Yes 2 ☐ No

25. Wes cese referred to medica exeminer? 1 Yes 27. Menne of D 1 D Naturel

5 Pending investigation 6 ☐ Could not be

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of injury (Month, Dey Year) 28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 \ Homicide

1/2 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

SEP 2 5 2000

D39296

200 Memorial

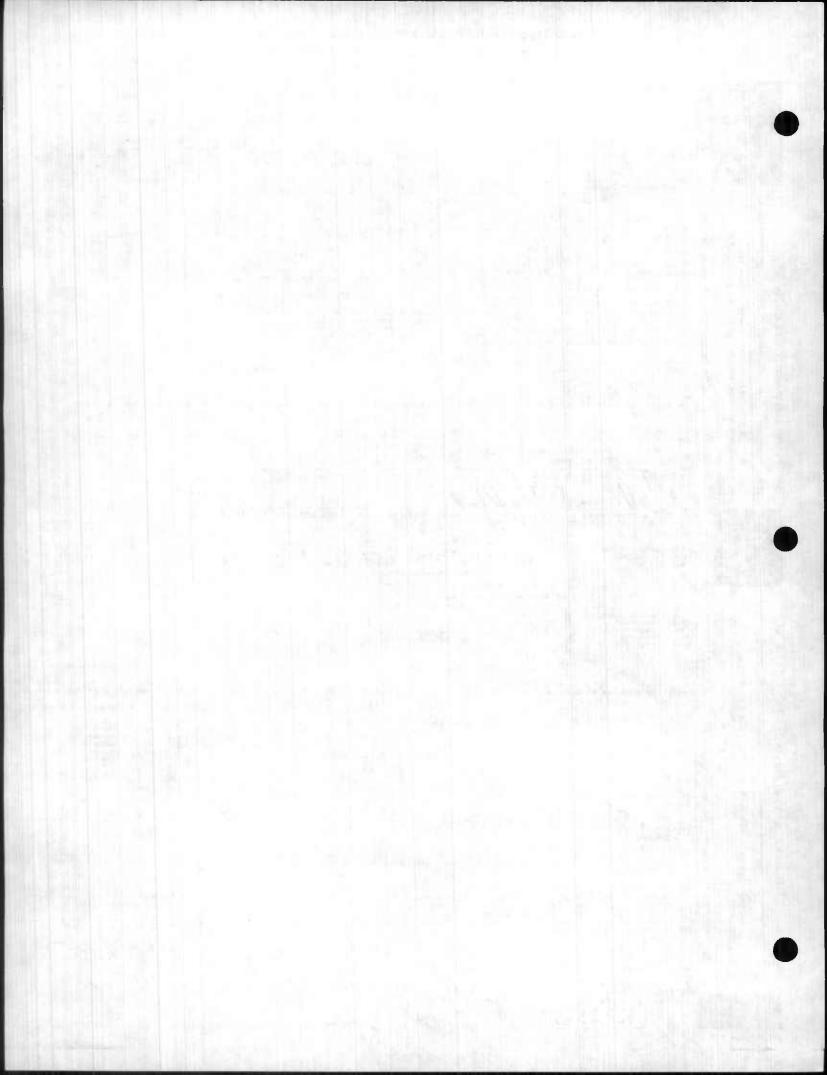
29c. License number

29d. Date signed (Month, Day, Year) 2000

R. Ricketts MD 31. Dete filed (Month, Dey, Year)

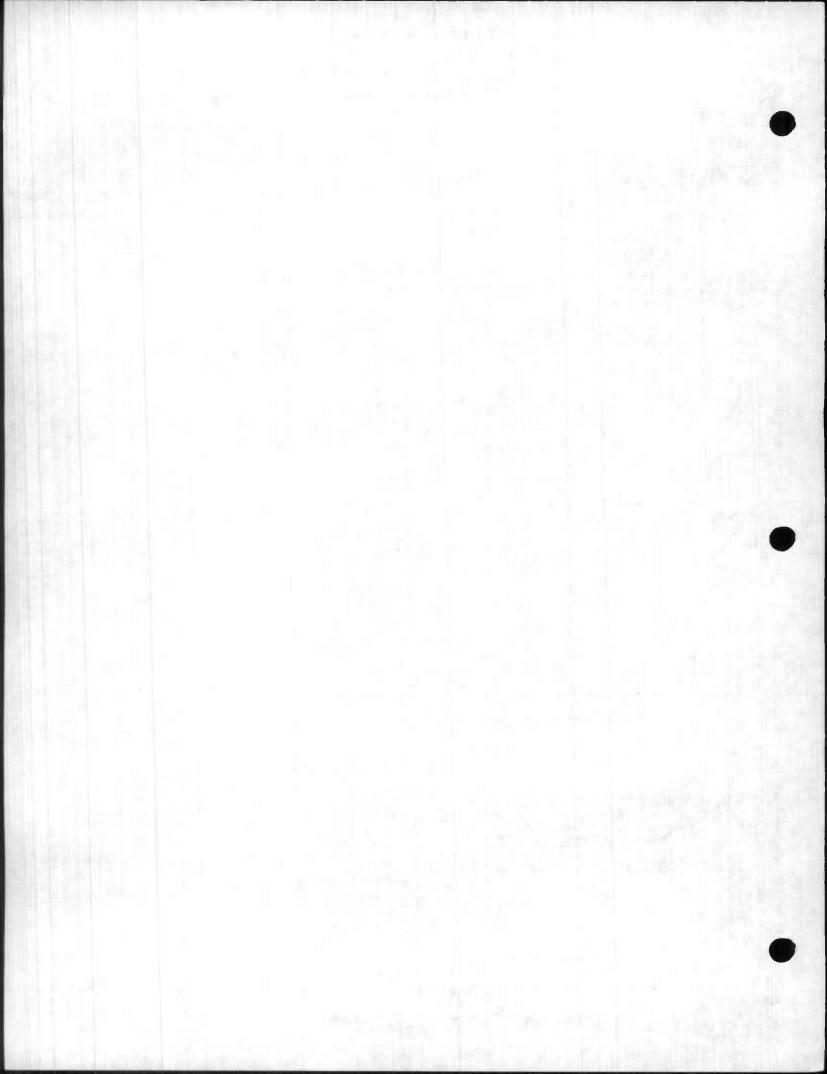
32. Registrer's Signeture

State Registrar



State of Maryland / Department of Health and Mental Hygiene 0 0 323 17

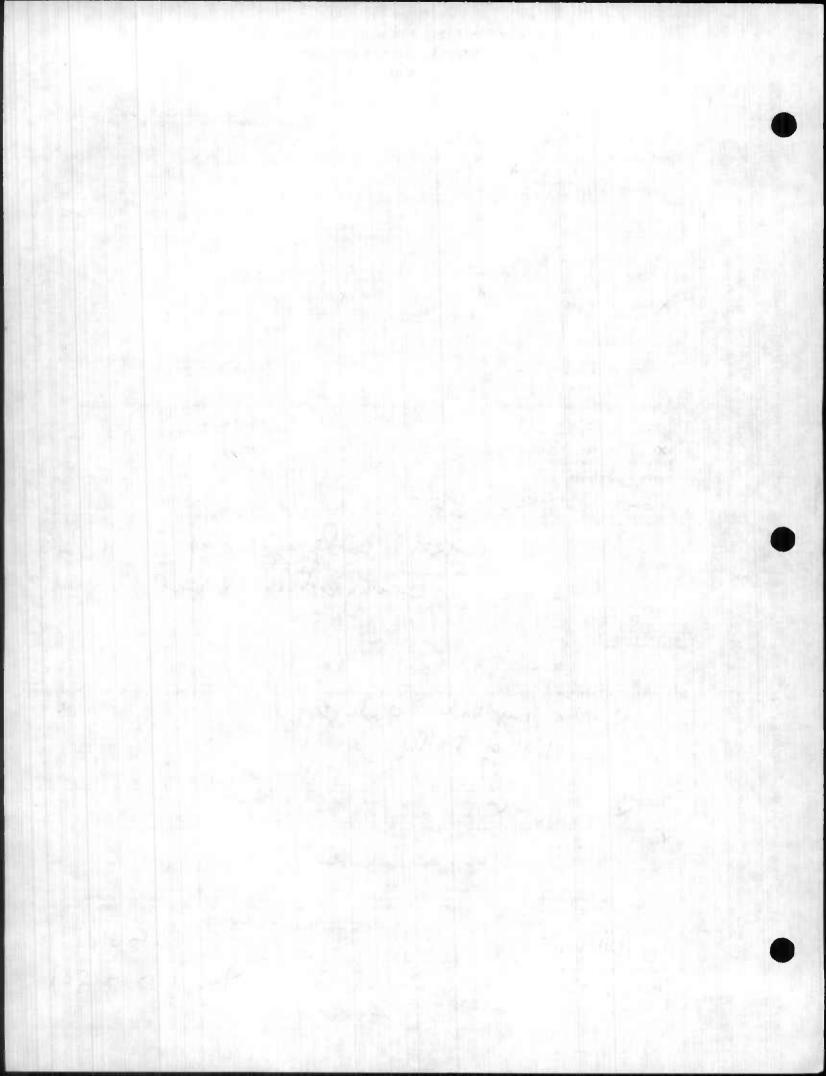
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Examiner		or Location of Death	4c. County	of Deeth						
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ylend	10a. State 10b. County 10c. City, Town or Location									
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or 28	10e. Street and Number 10f. Zip Code		10g. Citizen of V	Vhet Country?						
23a 23a met b	13990 Frederick Road 21794		U.S.A	•						
r dea	11. Meritel Status 12. Wes Decedent Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuben, Maxican, Put	(Specify Yes or No arto Rican, etc.)								
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72 h natu	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of w	vorking	16b. Kind of Bu	usiness/Industry						
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Hygie A		leme (First Middle								
ad be de de de de de de de de de de de de de	Table Dalacet Character C	2. Dete of Death Month SEP 25 2000 3:38A 2. Dete of Death Month SEP 25 2000 3:38A City, Town, or Location of Death COLUMBIA COLUMBIA COLUMBIA COLUMBIA HOWARD Inder 24 Hrs. B. B. Dete of Birth Month Day, Year Many 29, 1918 9. Birthplace (State or Foreign County) Mary 1 and Inder 14 Hrs. B. Dete of Birth Month Day, Year Mary 1 and Inder 24 Hrs. B. Dete of Birth Month Day, Year Many 29, 1918 10d. Inside City Limits 1 2 4 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2								
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mit.		OME C CITY	DDF /D	105)						
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the d	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.									
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quira:		24a. Was	en eutopsy	24b. Ware eutopsy finding						
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	25. Wes case referred to medical 26. Place of E	Death (Check only	ona)	Α						
	examiner? 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5□ Rasi	denca 6 □Oth	ar (Specify)						
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S E E										
Hosp 24 ho Fune Hely fi	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledga, death occurred at tha time, date and plate (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and plate of examination and occurred at the time, date and plate occurred at the time, date occurred a									
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F × F 8	18 1.11		C - 1	010						
	20 Name and address of person who completed arms of death (then 200) (Time Both)		-> ep remb	er d6, d000						
	30. Name and addrass of person who completed cause of deeth (Item 23a) (Type, Print) Steven Geller MO 9581 Old Annant. Rd	21/13	Ct. M	0 21042						
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Registrar	CED 2 7 2000 Deneva & South									
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State of Maryland / Department of Health and Mental Hygiene ()

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				Ce	runcate of	Death		Reg. No.					
Physician /Medical	1. Decedent's Nama (First, Midd Malinda Dor		2. Data of Da Month SEDTEM	ber a 6	ose 26 2000 /								
Examiner	4a Facility Nama (If not institution PENINSULA REGI	The state of the s			4b. City, Town, or SALISI		4c. County of Death WICOMICO						
Funeral Director	5. Social Security Number 215-07-1365A	6. Sex 1 ☐ M 2 💢 F	7. Aga (In yrs. 92	. last birthday) Yrs.	If Undar 1 Yaar Months Days			orth ay, Year) 0 1907		elaca (Stata or Foraign try) yland			
v	Usual Rasidence of Decedant	-											
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a Ma	Maryland Wico	omico	F	ruitla	and					1. Yas 2 □ N			
with the Mary s or 28s-f sh be notified.	10e. Street and Number				10f. Zip Coda			10g. Citizen of		itry?			
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O after or the miles	1 ☐ Nevar Married 2 ☐ Mar	rried 1 Yas	2 No		1 Yas 2 No		10 1 110011, 010.7	Specify:					
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D -1 1 2	20a. Mathod of Disposition		20b.	Place of Dispo	osition (Nama of	ce) Cem	Data	20c. Location	- City or To	own, Stata			
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in in in in in in in in in in in in in i	21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility												
ESE S	1 C R	Stewart Funeral Home 821 West Rd.Salisbury, Md.21801											
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eath.	2 Accident invest	tigation			M 1[☐ Yas 2 ☐ No							
LIVISION OF VICAL INCOLORS, tal or Attending Physician: The law requires the staffer death. al Director: After this certificate has been signed in by the funeral director, page 2 should be Certification: To Be Completed by	3 Suicide 6 Could datan	mined 208. Flat	ca of Injury - At I ding, atc. (Spec	homa, farm, st ify)	traat, factory, office		28f. Location City or T	(Straat and Num own, Stata)	ber or Run	al Routa Number,			
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To the com	29b. Signatura and titla of certific	ar l			29c. Licar	nse number		29d. Dala sign	D-[0	() ()			
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Ł	TAN, COPST	ANTE	447-6	7 KCU	okzin	11, 50	nelen	+ MD) 2	1201			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** LYNN L. TEAL Sept. 21, 2000 2:20 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Home St. Mary's Leonardtown 8. Date of Birth (Month, Day, Year) June 21, 1 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (Stete or Foreign Country) **Funeral** 10 M 2 F Hours Months 84 Yrs. 216 05 9348 1916 Baltimore MD Director Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow Examiner must be notified at St. Mary's Mechanicsville Maryland Director 1 Yes 2 KDO 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 6 29585 Hearts Desire Drive 20659 United States items 23s Funeral death 12. Was Decedent Ever In U,S. Armed Forces? 1 Yes 25000 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours effer in of Health end Mental Hygiena. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 "natural", or 1 Yes 25 No Specify: White Specify à 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) 12 Legal Secretary Private 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Be Frieda W. Tews Daniel H. Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 sh Department of Health end Important: If itam 27 la m any Injury or other traum once. 29585 Hearts Desire Drive Mechanicsville MD 20659 Lynne E. Donaldson Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Sept. 26, 2000 20c. Location - City or Town, State 20a. Mathod of Disposition

Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park Elkridge Maryland 22. Name end Address of Facility ral Se Robert E. Evans Funeral Home, Inc. 16000 Annapolis Road Bowie, MD 20715 tenter the mode of dying, such as cerdiac or raspiratory arrest, 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter shock, or heart failure. List only one cause on each lina. Approximata Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Examiner the death certificate be executed Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last physicien s the buriel Box 68760, Physician/Medicai 950 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Part I. Division of Vital Records, P.O. 1 Yes 22 No 3 Probably 4 Unknown The law requires that signed b þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed page 2 s 1 ☐ Yes 2 3 No 1 ☐ Yas 2 ☐ No or Attending Physician: funaral director, 25. Was case raferred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yas 2 ☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Dev Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 | Homicide Hospital 16 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Matrical Examinar: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner matrices. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title o 29c. License number 29d. Date signed (Month, Dey, Year) 30 30. Name and eddress of person who

DHMH 16 Rev 6/95

State Registrar P.

2000

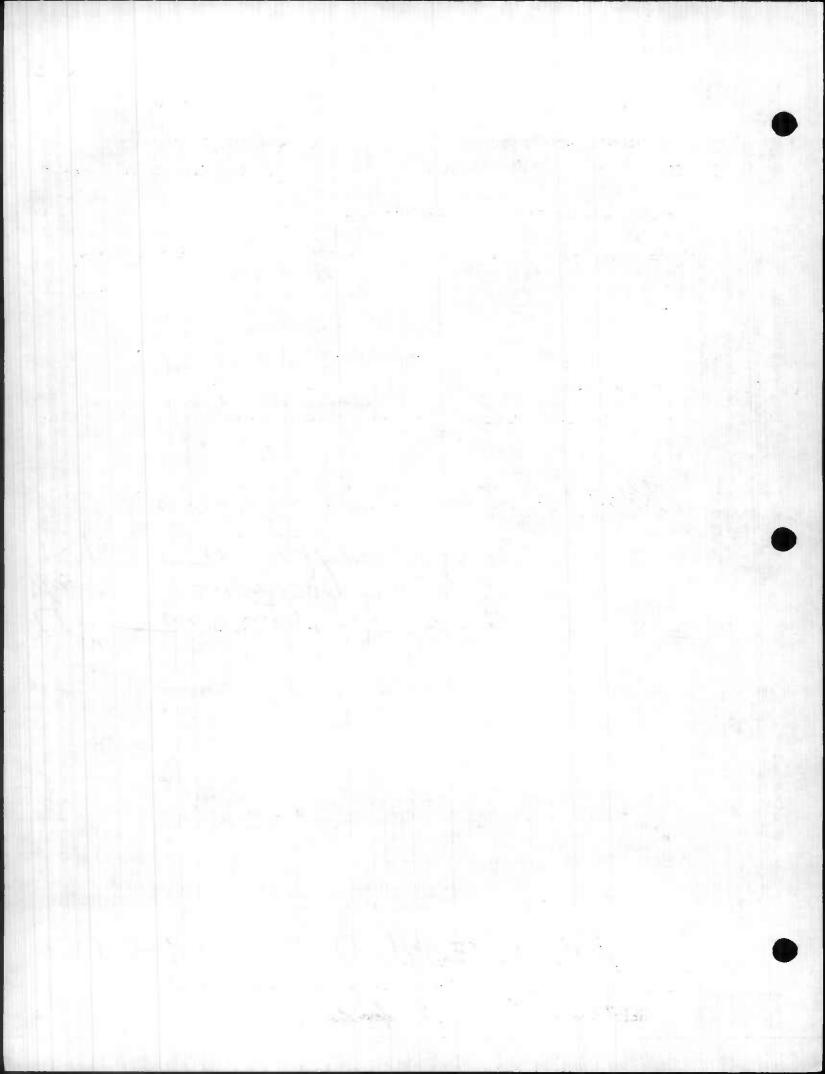
James

31. Dete filed (Mo

Jarboe.

2. Registrar's Signatura

24035 Three Notch Rd., Hollywood, MD 20636



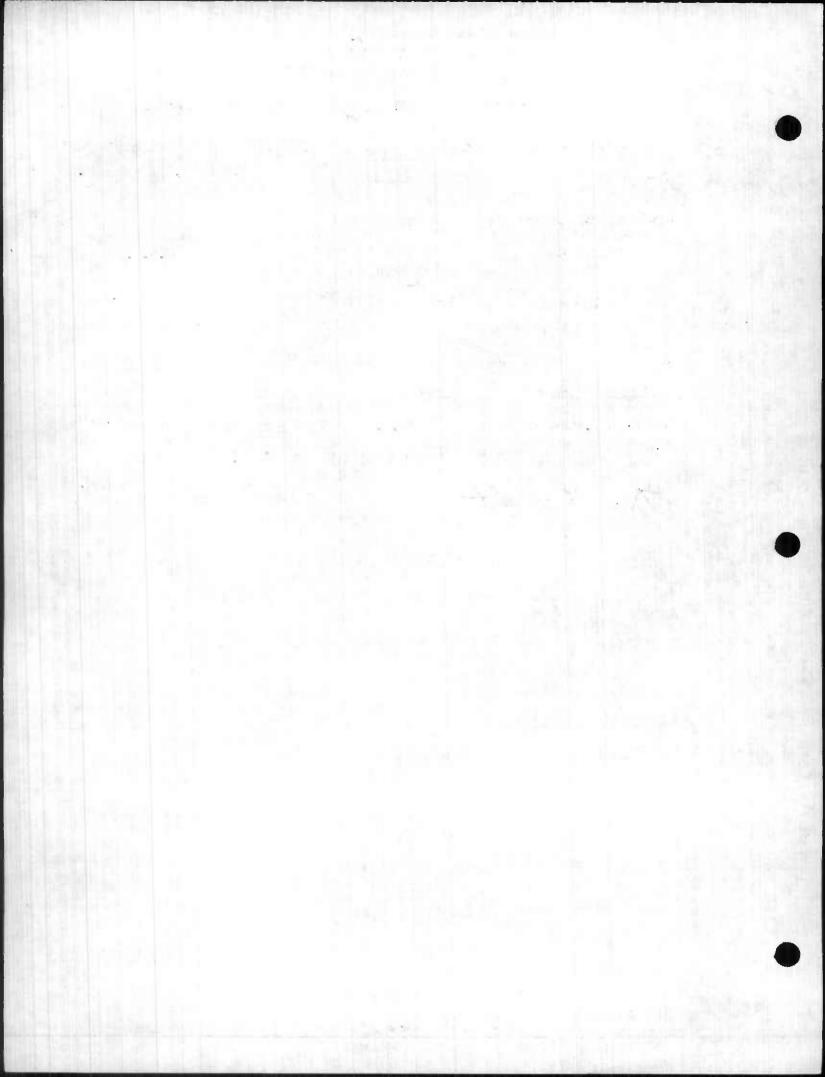
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Day 23, 2000 **Physician** Ralph Eugene Talkington 0105 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Clinton
If Under 24 Hrs. 8. Data of Birth
Hours Min. (Month. Day, Year)
March 19,1927 Southern Maryland Hospital Prince George's 7. Aga (In yrs. last birthday) 73 Yrs. If Under 1 Yaar 9. Birthplace (Stata or Foraign Country) West Virginia **Funeral** 1X M 20 F Months Days Director 579-24-5492 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 le marked other than "natural", or Nama 23a or 28a-f show treumatic avent, the Medical Examiner maint be notified at 1 Yas 2 No Maryland Prince George's Director Forestville 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 5904 Cheryl Lane 20747 U.S.A. Funeral 12. Was Decedent Evar in U.S. Armed Forcas? ND Vas 2 □ No 1944— If Yes, Giva Yaar or Datas: 1945 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11, Marital Status Black, Whita, atc. 72 hours after 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th N/A Engineer Railroad 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan 8 Mental I 2 Clemmie Edward Talkington Hulda Hayes. 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Coda) permit. Peges 1 and 2 sh Department of Heelth end Important: If item 27 is m sny injury or other treum once. Margaret E. Conway (Friend) P.O. Box 47706 Forestville, Maryland 20747 20b. Place of Disposition (Nama of camatary, crametory or other place) Sept Maryland State Veterans 20a. Mathod of Disposition Burial 2 Cremation 3 Removal from Stata Cheltenham, Maryland 4 □ Donation 5 □ Other (Specify) 22. Nama and Addrass of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton , MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intarval Between Onsat and Death **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical dA45 Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of) 68760 that initiated evants rasulting in death) Last Dua to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. å 1 Yes 2 No 3 Probably 4 Unknown vigned by AN MIMMUM DISEASE by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ALKINGTON 1 Yas 20 No Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) axaminar? Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No 2 # Certification: 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 Natural 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) A Maria 4 T Homicide To the Hospital within 24 hours a To the Funeral C 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, and dua to the causa(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, deeth occurred at the time, dete and place, and dua to the ceuse(s) and manner stated. edical 29a. Cartifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (item 23a) (Type, Print) IDRAL. VARNER, · 11701 Livingston Rd M.D. 31. Data filed (Month, Day, Year) SEP 2 6 2000 32. Registrar's Signatura

wants!

ORIGINAL

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev **Physician** Dorothy Ethel September 27, 2000 2:40 am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Spa Creek Center Genesis Eldercare Annapolis Anne Arundel If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Min. 1□M 2₩F Hours Months Days Yrs. Sept. 10, 1922 78 Washington, DC 578-18-2493 Usual Residence of Decedent 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 No Directo Maryland Forestville Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 U.S.A. 2814 Viceroy Avenue Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 14. Raca - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cottege (1-4or 5+) 12 D.C. Government Purchasing Agent 18 Mother's Name (First Middle Maiden Sumame) 17. Fether's Name (First, Middle, Last) Ethel Marie Neff Milton R. Russell 19b. Malting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4476 Owensville-Sudley Road, Harwood, MD 20776 Richard D. Swain - Son 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 □ Commation 3 □ Remove from State 4 □ Donarion 5 □ Other (Specify) Cemetery 9/30/2000 Suitland, Maryland 21. Signature of Funeral Service Ligari 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 23a. Part-Enter the disease, or complications that caused the dulth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20781 Approximate Intervat Between Onset and Death mouth Immediate Cause (Final disease or condition resulting to death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? MRSA BRONCHINS 1 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 10 THYROU 2 2 NO 1 Yes t ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No 2 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Tes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

been signed by the attending physician and should be deteched for use as the burial-transit The law requires that the death certificate be executed Records, After this certificate has Division of Vital Mospital or Attending Physician: n 24 hours after death. Funeral Director: After this certific pastely filled in by the funeral director, Physician: Vithin 24 hours a To the Funeral D 2

Director

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Herns 23a

natural', or

th end Mental Hyglene.
7 Is marked other than "natur treumstic event, the Menter

Provis 1 and 2 should be fill ment of Health end Mental H

Physician

/Medical Examiner

the

filed within 72 hours after death

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Examiner must be notified at

David S. Krimins, M.D., 104 Ridgely Avenue, Ste. #301, Annapolis, MD 31. Date filed (Month, Day, Year) State SEP 2 6 2000 Registrar

nun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and this of cartific

32. Registrar's Signature DOLLA

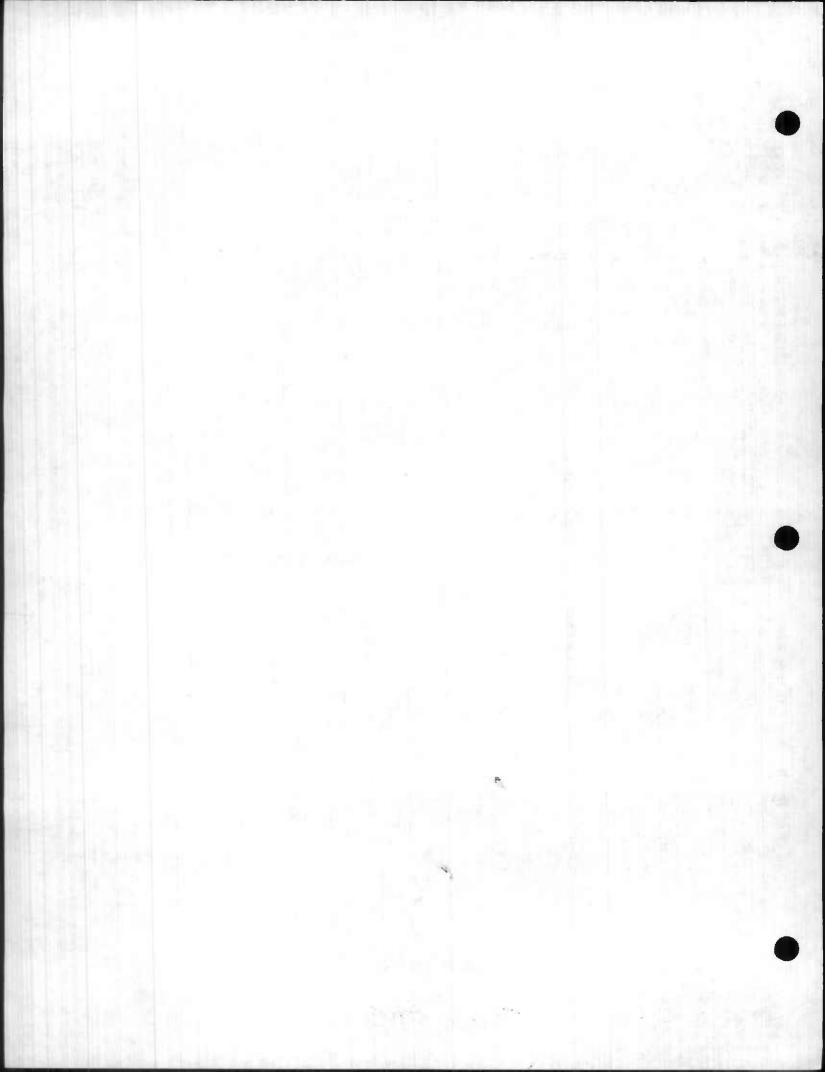
DHMH 16 Rev 6/95

29c. License number

29d. Date signed (Month, Day, Year)

September 27, 2000

21401



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 2. Data of Daath 1. Decedent's Nama (First, Middla, Last) Month 4:50 pm Physician Margan IGNN ep Ember 17 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner or three st Randelstown Baltimore HOSPI ta If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6 Sax 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) Funeral 496-18-0670 1€MM 2□ F 85 Yrs Director 2-20-15 Nebraska Usual Rasidence of Decedant the Meryland 10e. State 10b. County 10c. City, Town or Location 10d. Insida City Limits r 28a-f show N.C. Cabarrus 1 Yas ANO Concord Director 10e. Street and Number 7701 Untz Rd 10f. Zip Coda 10g. Citizan of What Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be 28025 U.S.A. Peges 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
wit: if item 27 is marked other than "natural; or Items 23 mry or other traumatic event, in "Maginal Energy or my and the statements." Funeral 12. Was Decadant Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black, Whita, atc. 1 Navar Marriad 2 X Married Baltimore, Maryland 21215-0020 1 Yas 3€No Specify: Specify: Black p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Clergy Minister 5 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) William Tann Bonita Morgan 2 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. informant's Name/Ralationship (Type, Print) 7701 Untz Rd Concord NC Marie P. Tann (Wife) 20b. Placa of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Gethsemane Cemetery 9-22-00 Charlotte N.C. 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata permit. Pege Department of important: if any injury or 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Long & Son Mortuary SVC 21. Signature of Funeral Service Lice 2312 Beatties Ford Rd Charlotte NC28216 of complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, ast only one cause on each line. Approximata Intarval Batwaan Onsat and Death Entar th disaasa failura. shock, or haa **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical One hour Examiner Dua to (or as a consequence of) Examiner that the death certificate be executed physician end s the burial-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Lest Dua to (or as a consequence of): P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) ettending ph signed by the e Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy been completion of cause of death? page 2 hes 1 Yas 2 No certificate Hospital or Attending Physician: 24 hours efter death. 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Daath (Chack only ona) Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 10 1 Inpatient 2KIER/Outpatient 3 DOA After this funerel 28d. Dascribe how injury occurred 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Matural 5 Panding efter death. Director: Af 1 Yas 2 No Invastigation 2 ☐ Accident 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify) 4 Homicida 24 hours Funeral 29a. Cartifiar 🕰 Cortifying Physician: To tha bast of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. Wedical ek 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. (Check only one) To the within 2

29c. Licansa numbar

5401 Old Court Rd Randelstown Md

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m who completed causa of death (Itam 23a) (Type, Print)

32. Ragistrar's Signatura

M.D.

29d. Data signed (Month, Day, Year)

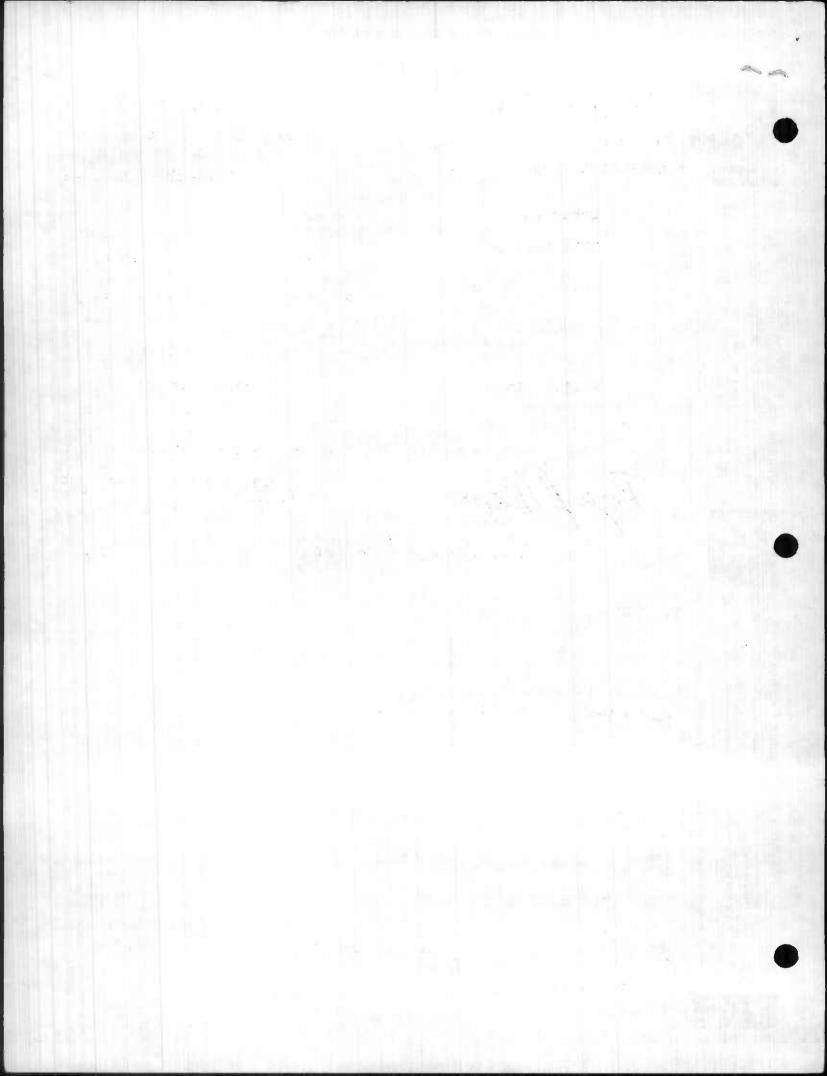
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Registrar

29b. Signature and title of certifier

SEP 2 8 2000

Lyle Campbell

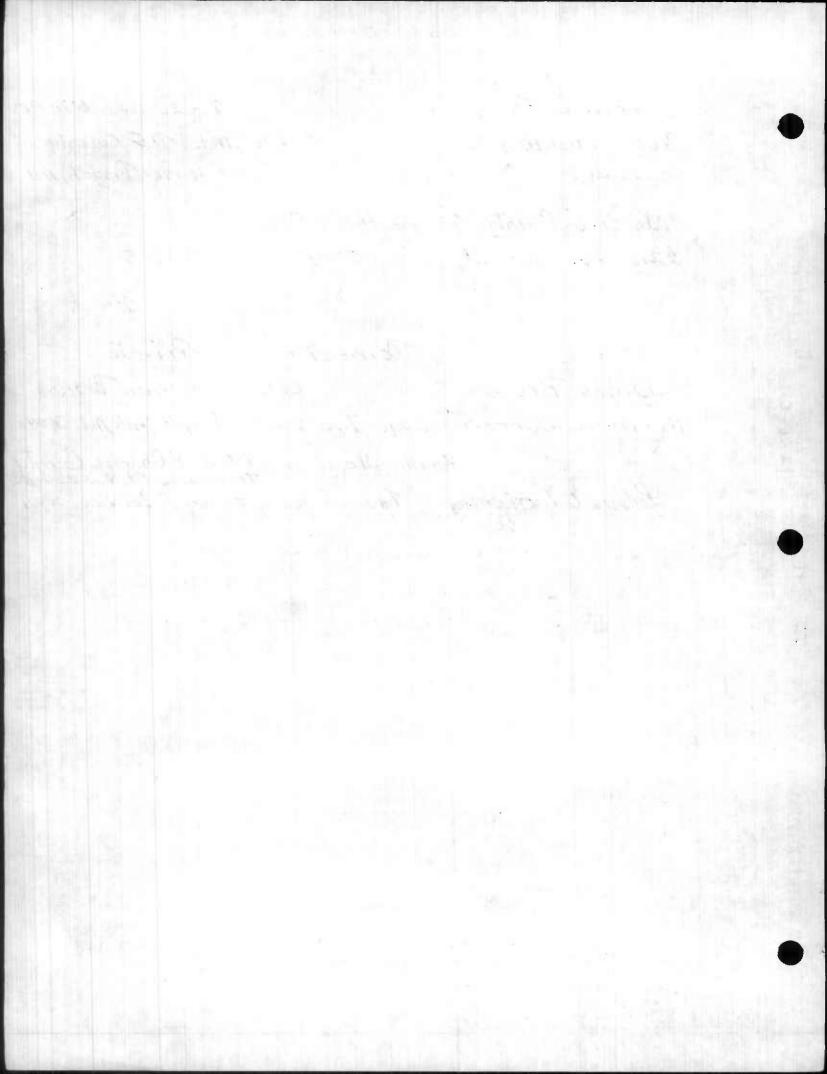


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** arrie L. 26-2000 /Medical Facility Name (If not institution, giva str 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern md. Hospital 5. Social Security Number 6. Sex 7. Age (Inton. P. G. County 9. Birthplace (State or Foreign Scountry) If Undar 1 Yaar 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Funeral 1 M 20 F Months Days Hours 075 - 22 - 4866 Usuat Residence of Decedent 98 Misgah, Director 10a, Stata 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or hems 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 Yas 2 No Director 10e. Street and Number 10g, Citizen of What Country? 20 744 § 13. Was Decedent of Hispanic Origin? (Specify Yas or Noif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indian, 2216 on Funerai 12. Was Dacadent Evar in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Important: if item 27 is marked other than "natural", or any injury or other traumatic event, the Marient Expension Specify: Black 1 Yes 2 No Specify: by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12), Cotlege (1-4or 5+) Hygiene # Grade Maryland 17. Fathar's Name (First, Middla, Last) 18 Mother's Name (First Middle Maiden Sumame) Be end Mental alice Bowman Brown James 19a. Informant's Name/Relationship (Type, Print) GrANDSON 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cematery, cramatory or other place) Herman 20a. Method of Disposition Jemple Hills Md. 20748 20c. Location - City or Pages 8 1 DeBurial 2 Cramation 3 Removal from Stata P. Gharles 4 ☐ Donation 5 ☐ Other (Specify) 9-30-00 Chapel 21. Signature of Funaral Sarvice Licenses 22. Name and Address of Facility 23a. Part. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tuneras 2001 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Due to (or as a consequence Physician/Medical Examiner been signed by the attending physicien and should be detached for use as the bunal-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseasa or injury that initiated avents rasulting in death) Last certificete be execu Due to (or as a consequance of): Thompson, Corrie Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown py 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To eral Director: After thi Date of Injury (Month, Day Year) Manner of Death 1 Netural 2 Accident 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending 5 Pending invastigation 1 Yes 2 No death 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide To the Hospital of within 24 hours a To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceusa(s) and manner as stated. | Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licensa number 14156 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) CROP Worterrez, W.D., 1300 Wercautile lave - Laveo eo A Worterrez, 20774

State Registrar 31. Date filed (Month, Day, Year) SEP 2 8 2000

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32. Registrar's Signatura

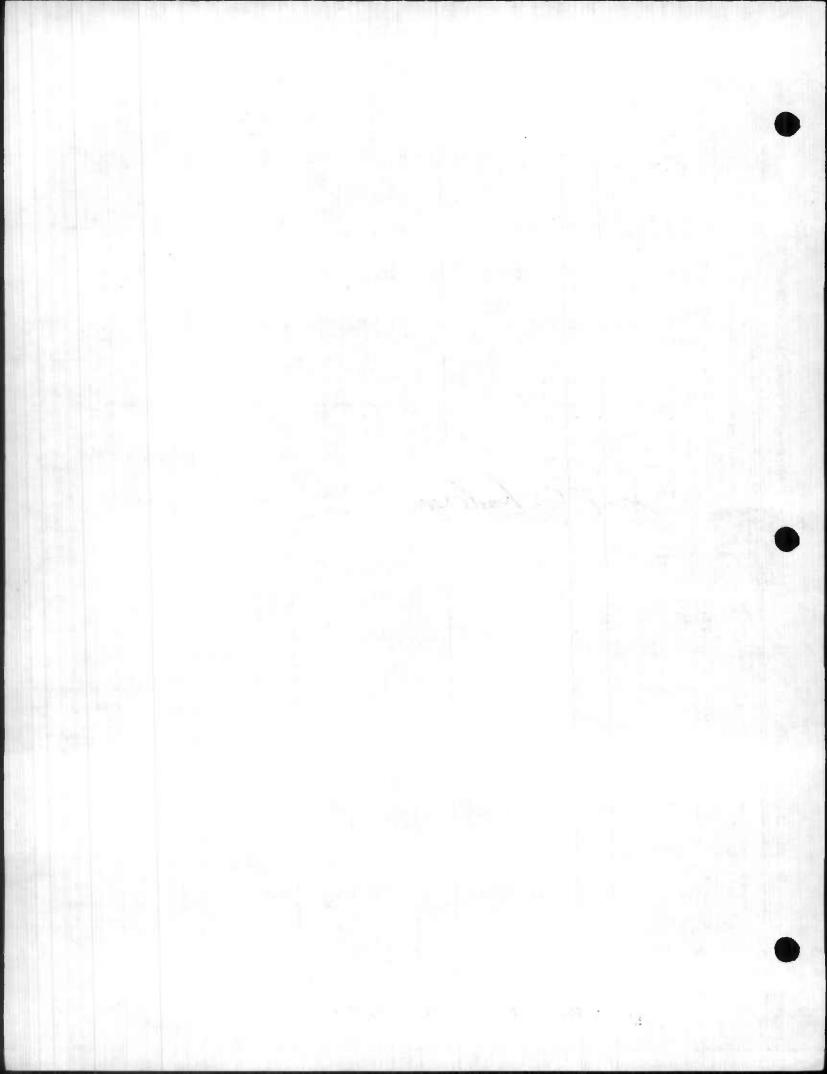


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 3. Tima of Death 2. Data of Death Month Day **Physician** ANNTE THOMPSON September 23, 2000 11:15 P.M. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Yaar Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) ADTIL 5, 1924 9. Birthplace (State or Foreign **Funeral** Hours 10 M 20 F Virginia 578-38-9566 76 Yrs. Director Usual Residence of Decedent the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d Insida City Limits permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Merylen Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f ahow with injury or other traumatic avent, the Medical Exacts a must be notified at each. Yes 2 No Director Maryland Prince George's Capital Heights 10a Street and Number 10g. Citizen of What Country? 10f. Zip Code 1323 Eastern Avenue 20743 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Ever in U,S.
Armed Forcas?
1 Yes 2 No
If Yas, Giva Race - American Indian, Black, Whita, atc. 11 Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 Widowed 4 Divorced Year or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Damestic 18. Mothar's Nama (First, Middle, Maiden Surnama) 17. Father's Nama (First, Middla, Last) Be Henry WIlliams Carol Williams 19a. Informant's Name/Relationship (Type, Print) Mr. Charles E. THompson (Husband) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1323 Eastern Avenue Capital Heights, Maryland 20743 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from Stata Forest Hills Memorial Cardens 9/28/2000 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Spriatum M Funeral Service License 22. ROLLINS FUNERAL HOME, INC. 4339 HINT PLACE, N.E. WASHINGTON, D.C. for the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, heart failure. List only one cause on each line. Onset and Death **Physician** /Medical Immediata Causa (Final diseasa or condition resulting in death) 8 Day maon 12 Examiner Due to (or as a consequence of) Examiner Regues sician and burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. P.0. 1 Yes 2 No 3 Probably 4 Unknown Records, ò 24b. Wara autopsy findings available prior to complation of cause of death? ahould Completed 24a. Was an autopsy performed? page 2 1 Yes 2 No 1 ☐ Yas 2 ☐ No of Vital or Attending Physician: 25. Was case refarred to medical axaminer? 26. Place of Death (Check only ona) Certification: To Be Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Manner of Death 28b. Tima of 28c. Injury at Work? After Division 5 Pending investigation 1 Natural e Hospital or Attending n 24 hours after death. e Funeral Director: Aft 1 TYas 2 No 2 ☐ Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) á 4 | Homicide filled in 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to tha cause(s) and mannar as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to the causa(s) and manner stated. 29b. Signature and little of partifie 29c. License number 29d. Data signed (Month, Day, Year) M1) D45660 9.25-2000 30. Name and address of person who completed cause of death (from 23a) (Type, Print) 124, Boaie MD CALLDNT CN 143001 te X 22. Registrar's Signature 31. Data filed (Month, Day, Year) State

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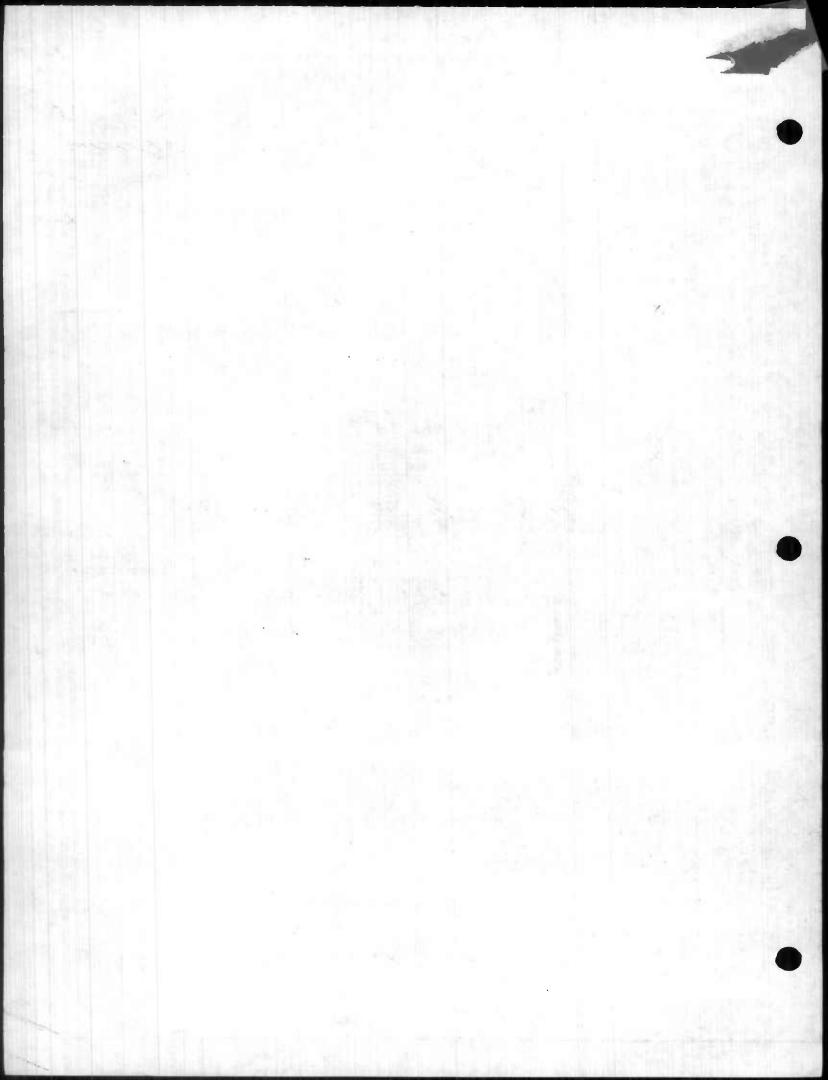
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	/Medical Examiner	4a Facility Name (If not institution, give stre Calvert Memorial H	A STATE OF THE STA		Acres de la constante de la co		r Location of Death rederick		of Deeth Lvert		
	Funeral Director	212-54-6660	-0-	51 Yrs. Isst birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			n (Month, De	th y. Year) 4, 1949	9. Birthplaca (State or Foreign Country) Maryland		
	show	Usual Residence of Decedent 10a. Stata 10b. County	10c. Cit	y, Town or Lo	ocation			10d. Insid			
	vith the Ma or 28a-f s be rout a	Maryland Calvert			St. Leona 101. Zip Code			10g. Citizen of Wi	hat Country?		
20	within 72 hours after death with the Maryland ene. than "natural; or items 23a or 28s-f show he Madcal Eventher must be rooffed at symbleted by Funeral Director	5906 Hillside Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U. Armed Forces? 1 XYes 2 No 190 If Yes, Give	67-	206 Was Decedent of H If Yes, specify Cubin 1 □ Yas 2 ② No		(Specify Yes or No erto Rican, atc.)		SA - American Indian, k, White, etc. Black		
Baltimore, Maryland 21215-0020	ed within 72 hours ygiene. er than "natural", rt, the Wides Exit.			16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired graph Spe	during most of w		16b. Kind of Business/Industry Secret Service			
and 2	Hygid Hygi	17. Father's Name (First, Middle, Last)	Tyler	1019	graph spe	18. Mother's N	18. Mother's Name (First, Middle, Maiden Surname) Louiseana Chew				
Mary	and land	19a. Informant's Name/Relationship (Type,	formant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I								
more, I	m 2 m 2	Patsy Tyler/Wife 20a. Method of Disposition 1 (X) Burial 2 Cramation 3 Rem 4 Donation 5 Other (Specify)	noval from State	Date 20c. Location - City or Town, State 10/7/00 Port Republic, MD							
Balti	permit. Pages Department of Himportant: If the any Injury or of once.	21. Signature of Funeral Service Licensee	uneral Ho ce Freder	ome rick, MD 20678							
	Physician	23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that causad the deatl cause on each line.	h. Do not ent	er tha moda of dyir	ng, such as cerd	iac or respiratory a	rrest,	Approximate Interval Between Onsat and Death		
	/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) a	Cav Due to (o	CINO ras a consec	quence of):	malig	nant-		8 mintls		
oʻ.		Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying									
x 68760,	certificate be nding physicil use as the bu	Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequenca of): d. Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 2 No 3 Pro									
.O. Box	es that the death certification of the attending post detached for use as by Physician/Me	Part II. Other eignificant conditions contrib	outing to death but not rase	ulting in tha u	ndarlying causa giv	an in Part I.	23b. Did	tobacco use conf	tribute to the cause of death?		
0	± 00 >			- 12-1			10	Yee 2 No	3 Probably 4 Unknown		
of Vital Records,	aw requir	2-71-14-17-24						en eutopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?		
al R	certificata harrector, page	25. Was cese referred to medical					10		1 Yes 2 No		
	7 50 5	examiner?	pital: 1 Inpatient 2 2 28a. Dete of Injury (Month, Dey Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injui	er: 4 Nursing	Home 5 Resi				
Division	rs after death. Is Director: After to the tuner led in by the tuner. Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		reet, factory, office		28f. Location (City or To	Street and Numbe wn, State)	er or Rural Route Number,		
	Hospi 24 hou Funer staty fii	29a. Certifier (Check only one) 1 Certifying Physici 2 Medical Examiner	an: To the best of my kno- On the basis of examinat and manner stated.	wledge, death tion and/or In	n occurred at the til vestigation, in my o	me, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) end mer dete end place, e	nner es stated. Indidue to the ceuse(s)		
D	To the within To the comple	29b. Signature and talle of certifier M. 78	whom		29c. Licens	3992	0		(Month, Dey, Year)		
6-	+1	30. Name and address of person who comp John Brooks, M.D		23a) (Type,	Print)	Prin	nce Frede	rick, MD	20678		
	State Registrar	31. Date filed (Month, Day, Year) OCT 0 2 2	32. Registrar's Signa	ture	5 for	de					

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TO SEE TOO

00-5247-033 UNK 00-262

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State of Maryland / Department of Health and Mental Hygiene

Da	vid Venso	on		Се	rtificate c	f Death	Re	g. No,	32321				
1	Physician /Medical	1. Decedent's Nama (First, Middla, LL DAVID	1. VENS	ON				Month Day Year EPTEMBER 16 2000					
	Examiner	4a Facility Nama (If not institution, gir PRINCE GEORGES	A street and number) HOSPITAL			4b. City, Town, o	Location of Death	4c. County PRINCI					
ŀ	Funeral Director	5. Social Security Number 6.		n yrs. last birthday) 19 Yrs.	If Under 1 Ya Months Da	ar If Undar 24 Hi	s. 8. Data of Birth						
	2 .	Usual Rasidence of Decedent 10a. Stata 10b. County	11	Oc. City, Town or Lo	ocation				10d. Inside City Limits				
	or 28s-1 show be notified at Director	MARKE AND DRINGE			REST HGH				1∭X(as 2□No				
		10e. Street and Number 4301 23RD PLA			10f. Zip Cod 2074	8			ED STATES				
020	raf, or Here 23. Examiner must by Funeral	11. Marital Status 1 🕽 Nevar Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eva Armed Forces? 1 Yas X No If Yas, Give Yaar or Datas:	ar in U,S. 13.	Was Decedent of Yas, specify C		Specify Yas or No- into Rican, etc.)	Blac	e - Amaricen Indian, ck, Whita, etc. BLACK				
21215-0020	ed within 72 ho ygiene, ver than "natural, the Medical. Completed	15. Decedent's E (Specify only highast gr Elementary/Secondary (0-12) 1 2 TH	ducation ada complated) College (1-4or 5+) 1 YEAR	16a. Dece (Giva lifa.	dent's Usuai Oc kind of work do DO NOT usa rel	cupation na duning most of w ired)	orking		Businass/Industry				
	tal Hygi d other event, I Be Co	17. Fathar's Nama (First, Middla, Las.			ONEMPL		ama (First, Middle, A		N/A ra)				
Maryland	Menta Menta artice To E	TONY E. V	ENSON			DARI	ENE J. CL	ARK VE	NSON				
Mar	A 2 sh h and h sm resum	19a. Informant's Name/Raiationship					Rural Routa Number,		0074				
more,	Pages 1 and and of Hoati it: If leen 2 y or other	VIRGINIA E. WAI 20a. Mathod of Disposition MCBurial 2 Cramation 3 [4 Donation 5 Dother (Special	Ramoval from Stata		osition (Nama of matory or other	olace)	Data	20c. Location -	City or Town, Stata				
Balti	Departm Departm Importar any Injur	WASHINGTON NATIONAL CEM. 9-26-2000 SUITLAND, No. 22 Name and Address of Facility DUDLEY FUNERAL HOME 3200 RHODE ISLAND AVE., MT. RAINIER, M.											
	Physician /Medical Examiner	23a. Part1. Entar tha disaasa, or con shock, or haart failura. List only Immediata Causa (Final disaasa or condition rasulting in death)	. Our	efot l a to (or as a consa	Loupo	ds of	Head	2	Approximata Intarvel Batween Onsat and Death				
Box 68760,	seth certificate be executed attending physician and for use as the bunal-transit clan/Medical Examiner	Cause (Disaase or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of):											
	et the deeth cend by the attendineteched for use	Pert II. Other significant conditions	contributing to death but r	ot rasulting in tha	undarlying causa	givan in Part I.	23b. Dld to	bacco use co	ntributa to the cause of death				
, P.O	requires that the death cent seen signed by the attendin hould be deteched for use eted by PhysIcian/N					D5 34 L	1 🗆 Y	• 2 No	3 Probably 4 Unknow				
Records,	_ 0 0 _						24a. Wes a perform		24b. Were eutopsy findings available prior to complation of ceusa of death?				
I Re	The lew page 2						1 Va	as 2 No	Vas 2□ No				
Viital	clan: entific ector,	25. Was cesa rafarred to medical axaminar?	Hospital:			26. Place of D	eath (Check only on	a)					
of	Z Sp C	1 ☐ Yas 2 ☐ No 27. Mennar of Death	1 Xppatient 26s. Date of Insury (Month, Jay Y	2 ER/Outpatia	INT 3LI DOA	njury at Work?	Homa 5 ☐ Rasida 28d. Describe ho						
ion	Attending or death. ector: Afte by the fune iffication	1 Natural 5 Panding 2 Accidant invastigation		22 C		Vork?	Sub,	est (5ht				
Division	To the Heapital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	3 Suicida 6 Could not to determined	Plant of Injury building, atc. (- At homa, farm, st Specify)	treat, factory, offi	се	281. Location (St City or To	on (Street and Number or Rural Routa Number, Ton State)					
	n 24 hour n 24 hour he Funer pletely fill		nyelcian: To the best of miner: On the basis of ax	aminetion and/or in									
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in Medical Cert	29b. Signature and title of cartillar	and mannar states			ansa number			d (Month, Day, Year) ER 17,2000				
	(3)	30 Nama and addrass of person who	complated causa of daat	h (Itam 23a) (Type		n Street	. Baltimo	re. Mar	yland 21201				
	State Registrar	31. Data filed (Month, Day, Yaar) SEP 2 6 2.060	32. Registrar's	Signatura	long of	<u> </u>	, LAU. CHIRO	C) LILL	J				

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth Anoth Reg. No. Year

		Certificate of Death	R	leg. No.	360							
	-	2. Date of Deer Month		3. Tima of Death								
	Physician /Medical	Roma P. Vierbuchen	Septemb		2:15PM							
	Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town,	or Location of Death									
		Southern Maryland Hospital Center Cli	nton	Prince Geor	rge's							
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours	Jin Month Day	y Year) 9. Birthpler	ce (State or Foreign							
	Director	464-09-8735 1 M 2 T F 92 Yrs. Months Days Hours	June 8,	1908 Texas	S							
	and and	Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location		100	d. Inside City Limits							
	Many	Maryland Charles Hughesville		1 ☐ Yes 2X No								
	128s	10e. Street and Number 10f. Zip Code	1	10g. Citizen of What Country	y?							
	U36 urs effer death with the Manyland ali, or items 23s or 23s-f show through the control of the	6055 Trotters Glen Drive 20637		USA								
مره	death death	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuben, Mexican, P	? (Specify Yes or No-									
3	She of the Purity Purit	1 Never Merried 2 Merried 1 Yes, Give 1 Yes, Specify:	deno ricen, etc.,									
Tellam	and 21215-0036 be filed within 72 hours effer death with the Manylar stal hygiene. definer than "natural", or items 23a or 23a-1 ahow event, in with the first profit of the Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		***************************************								
3	121215-0(led within 72 hor hygiene. The than "natural". The transition of the completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of life. DO NOT use refired)	working	16b. Kind of Business/Indu	stry							
F.	within within then.	Elementary/Secondary (0-12) College (1-4or 5+) Clerk		Federal Gover	rnment							
4	offied other vent, in	17. Father's Name (First, Middle, Last) 18. Mother's	Name (First, Middle, I	Maiden Surneme)								
3	Maryland d 2 should be file th and Mental Hy r? Is marked othe traumatic event		a Mae Nann	v								
	should band Ments marked umatic e	19a. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number of		-	code)							
	Mand 2 and 2 27 is 27 is per tra	Marilyn Furr/Daughter Same as item 10										
15	Or He of He r other	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town	n, State							
	Page nent mrt: H	1 Burial 2 Cremation 3 Themoval from State 4 Donation 5 Other (Specify) Oakwood Cemetery 9/27/2	2000	Fort Worth, Te	exas							
014:15	Baltimore, Marylar permit. Pages 1 and 2 should by Ospariment of thealth and Menta Important: If tean 27 is marked any Injury or other traumatic enones.	21. Signature of Saharail Service Licensee 22. Name and Address of Fecility	Funeral Ho	те РА								
0	00 22558	21. Signature of Etherni Service Licensee 22. Name and Address of Fecility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745										
U		23a. Part 1. Enter the disease, or conditions that caused the deeth. Do not enter the mode of dying, such as cershock, or hart failure. List only one cause of each line.		rest, A	Approximate Interval Between							
3	Physician			1	Onset and Death							
(2000)	/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	2000	7	5days							
-	A STATISTICS	Due to (or as a consequence of			0							
124	68760, ficate be executed physician and s the burial-transit edical Examiner	b	8 68	1								
-), exacu n and ial-tra	Sequentially list conditions, if any, leading to immediate cause. First Indexing.										
0	P.O. Box 68760, that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Physician/Medical Examir	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of):										
		resulting in death) Last										
<	Box eath cert for use	d										
Roma	O. E. death he ath he ath he ath sich sich	Part tt. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in fact I.	/ 23b. Did to	obacco use contribute to t	the cause of death?							
Č	P.O. at the day the etache	Dementia Huperter c'au habel	0 5 10 Y	res 2 No 3 Probe	ably 4 Unknown							
a	0 2 88 6	Derrentie - 13 Sperieus d'age		0.45 14/0-	a de la constante de la consta							
-	Orc nequilibrated			med? avail	e autopsy findings lable prior to apletion of cause							
2	law law has be 2 s			of de	eath?							
5	Cor		1 D Y	es 2016 10	Yes 2□ No							
ierbuchen	Vital Record Iclan: The law require sertificate has been si rector, page 2 should	examiner?	Death (Check only or									
5	Of \Physic rthis of real directions of the re	1 Dispatient 2 EN Outpatient 3 DOA 4 Nursi		dence 6 Other (Specify) how injury occurred								
6	ding ding the time	27. Menner of Death 1 Lighturel 5 Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No										
-	Division or Attending after death. Director: After d in by the fune	3 Suicide 6 Could not be determined 28e. Place of thiury - At home, farm, street, fectory, office		Street end Number or Rural	Route Number,							
-	Distance of in the control of	4 Homicide building, efc. (Specify)	City or Tow	11, 3(6(6)								
	houn houn by fille	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and proceedings of the control of the c										
	Division of Vital Record To the Heaptal or Attending Physician: The law requir within 24 hours attendeath. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should Medical Certification: To Be Completed	one) and manner stated.										
1- 1	To t To t com	29b. Signature end title of certifier 29c. License number	71,	29d. Date signed (Month, D								
	7	Salvi V Challe D342,	14	9.25.	1000,							
	(.3)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1. 12 10	2 aring	2000.							
	9	CSSAM IETUWI ++UU UID Branch	40 B-10.	2 4/1/10	1,110							
1	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature										

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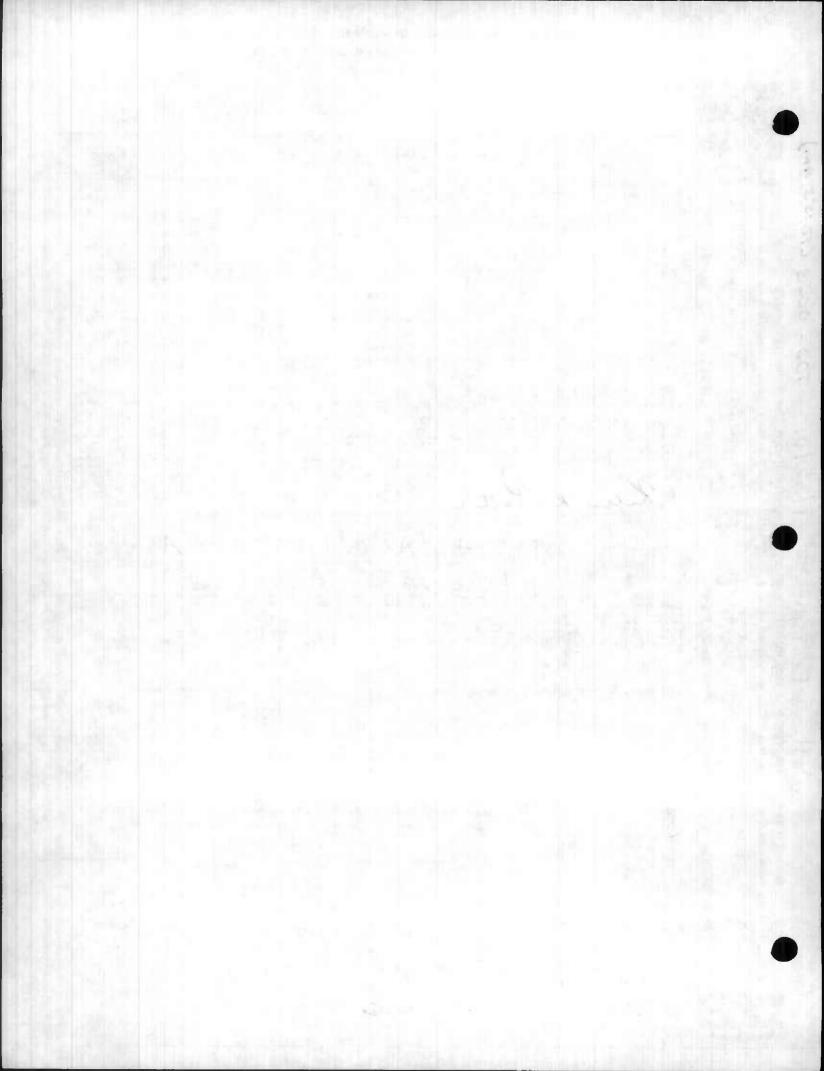
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Į.	Physician /Medical	LF	ENA	RICHMOND	WILLI	AMS						9	22	Z000	1147 PM
7	Examiner	4e Faci	lity Nama	(If not institution, giv	re street end numb	per)						cation of Death	4c. Cou	unty of Death	
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	Funeral		I Security		Sex I□M 2180 F	. Aga (In yrs. le 56	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day	Y, Year)	9. Birthp Coun	laca (Stata or Foreign try)
L	Director		410-78-7924								MISS	issippi			
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	Mar al	Mary	1and	Prince G	eorge's	Mit	chell	ville							to the second of the second o
	or 28s-f	10e. Str	eet end N					10f. Zip	Coda				10g. Citizen	of What Coun	itry?
	after death with the Maryland or Herra 23e or 28e-f show prinet must be notified at Finners I Director	170)1 Wi	11ow Oaks	Court				721				U.S.A.		
		11. Mari	ital Status		12. Was Deced Armed Force	as?	5. 13.	Was Deced If Yas, spec	ent of h	Hispanic Ori an, Maxica	igin? (Spi n, Puarto	ecify Yas or No- Rican, atc.)		Race - Amaric Black, White,	
21215-0020	Si Tal	3 🗆		rried 2½ Married 4 Divorced	1 ☐ Yas 2 If Yas, Giva Yaar or Dat			1□Yas 2	≥⊠ No	Specify:			Spe	ecity: Bla	ck
5-0	ed within 72 hours ygiene. wr then "natural", rt, or was a feet		(Sp	15. Decedent's E- ecity only highast gra					ing	16b. Kind o	of Business/Inc	dustry			
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	be filed withing tall Hygiene. Id other then event, the Handle Ha		er's Nem	a (First, Middle, Last		115	F	MILLIA	SCI		ar's Nama	a (First, Middle,			
an	should be filed withlind Mental Hygiene. marked other than imatic event, tree.	D	obert						Alean Taylor					,	
Maryland	and Menia marke		lormant's	Name/Ratationship (Type, Print)		19b. Meitic	ng Addrass	(Straa	1		al Routa Numba	r, City or To	wn, Stata, Zip	Coda)
M	0 0 0 0			L. Willia		ınd	1701	Willo	w O	aks C	ourt	, Mitch	ellvil	le. MD	20721
re,	of Heeith	20a. Ma	thod of Di	isposition		20b. Pl	ace of Dispo	sition (Nan	na of			Data		on - City or To	
E	Peges nent of rut: If Ith			2 ☐ Cramation 3 ☐ 5 ☐ Other (Special		ate	yland					9/28 2000	Chelt	enham,	Maryland
Baltimore	in the party of	21. Sign	nature of f	Funaral Sarvice Lice	nsee	1						L HOME			
0	Dep any sun an	•	Na	nam A	Perc	tie						Landov	er. Ma	arvlano	1 20785
		23a. Pa		r tha disaes, or come aart failura, ist only	plications that cau	used the death	. Do not ani	tar tha mode	a of dyi	ing, such as	cardiac	or raspiratory ar	rest,		Approximate Intarval Batween
	Physician														Onsat and Death
	/Medical Examiner	Immediata Causa (Final diseasa or condition resulting in death) Left Hemisphere Cerebral Infancian Dua to (or as e consequenca of): Cerebral Vasculitis									Hov	1	2 weeks		
	a de	1000				Dua to (or	as e conse	quenca of):			1-1	, _			2 weeks 18 months
	executed in and ial-transit			•	b				25	CUL	.06	5		- 1	8 Months
Ć.	rificete be executed to physician and es the burial-transit	if any, I	ntially list on aeding to Entar Uni	conditions, immediate derlying or injury nts		Dua to (or	as a consec	quanca oi).		,					
68760,	ficete be physicle is the bur	Causa that init	Disease diated ever	or injury nts	C	Dua to (or as a consequanca of):									
	os th	resultin	g in death	n death) Last											
Box	death cer e ettendir ed for use				d			-							
	the ethined for	Pert II. 0	Other sign	nificant conditions of	contributing to dea	th but not rasu	Iting in tha u	indarlying ca	ausa gi	van in Part	t.	23b. Did (lobacco use	contribute to	the cause of death?
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Records,	v requires that been signed b should be dete												an autopsy	av	era eutopsy findings allabla prior to
ecc	28 2										_			of	mpletion of causa deeth?
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Vital	ystoten: The list certificate he director, page	25. Was	s cesa ref	arred to medical		,					a of Deat	h (Check only c	ona)		
of				No No			ER/Outpatie		M		ursing Ho	ma 5 Rasio			5)
	After funer	27. Men	ner of De Natural	5 Panding	28a. Dete of (Month,	Day Year)	28b. Tima o Injury	M Z	8c. Inju	ork?]Yas 2□	No	28d. Dascribe I	now injury or	ccurred	
Division	after deeth. Director: After Jin by the fune	3 🗆	Accident Suicide	investigatio	9 200 Ptoss 5	f tnjury - At ho	ma farm st				1140	28f. Location (S	Street and N	umber or Run	al Route Number,
5	as for Attending P is after deeth. In Director: After the in by the funeral Certification:	40	Homicide	a datarmined	building	, atc. (Specify)		, 011100			City or Tov	vn, Stata)		
Ą	To the Hospital or Attanding Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification:		ertifier heck only ne)	1 Certifying Pr	nysician: To the bas	is of axaminati									
	within 2 To the comple		1	nd title of ogrtifler	/ / / Individual	stated.		290	. Lican	sa number			29d. Date s	igned (Month,	Day, Year)
	FSFO	Mely & Mason						1				23/0	0		
	(10)	30. Nam	na and ad	drass of person who	1		23a) (Typa,	Print)							
	0	Wesley 3. Mason MD, 10810 Connecticut Ave, Kensington MD 20895													
	State Registrar	31. Deta	s filed (Mc	P 2 6 2000	32 Reg	gistrar's Signat	ura	P					,	,	

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State of Maryland / Department of Health and Mental Hygiene 11 32331

						Certificate of	f Death		Reg. No.		2000	
	Physician	1. Decedent's Nam						2. Dete of De Month	eeth Day	Year	3. Time of Death	
	/Medical	Evelyn		ouise Wil				Sept 2			12:53 AM	
	Examiner			give street and numb			4b. City, Town, or Clinton	Location of Deat			George's	
2	-			nd Hospit		thdey) If Under 1 Yes		O Data of Bi				
Am	Funeral Director	5. Social Security 1 213 42 90	650	5. Sex 7 1 M 2 F 7	. Age (In yrs. lest bir 56	Yrs. Months Day		(Month, De			place (State or Foreign ntry) nington DC	
3	pu &	Usuel Residence of	10b. County		10c. City, Tow	n or Location					10d. Inside City Limits	
P	death with the Maryland rms 23s or 28s-f show rms to notified at	MD	Prince	George's							1 ☐ Yes 25 No	
12	the protect	10e. Street and Nu		deorge 5	71944	101. Zip Code			10g. Citizen of	Whet Cou	intry?	
5	With IDI			llips Roa	d		20608		Uni	ted S	States	
3	ifter death with the Mainter death with the Mainter French or 28m-1 and the mast be notified funeral Director	11. Merital Status		12. Was Deced	lent Ever in U,S.	13. Was Decedent o					ican Indian,	
200 - 0005	2 2 2 3		ried 2 Marrie	Armed Ford 1 Tes 2 If Yes, Give Yeer or Dat	XX **	If Yes, specify Co		to Hican, etc.)		Black, White, etc. Specify: White		
0 5	2 hor	1000	15. Decedent's	Education	16a.	Decedent's Usual Occ	upation	rkina	16b. Kind of 8	Jusiness/Ir	ndustry	
1 2		Etementery/Sec		grade completed) College (1-4	4or 5+)	(Give kind of work don life. DO NOT use reti	red)	rking	G7 '			
	filed with Hygiene rther than ant, the		12			Typist			Cleri			
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(1)	E B OF	Richard I		HUSBAND)		6101 St. Pl	nillips Ro	Date Date	20c. Location			
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7	permit. Page Department of Important: If any injury or once.		5 Other (Spe		Cedar	Hill Ceme	tery Sept	26, 200	0 Suitl	and,	Maryland	
2	permit. Departm importa any inju	21. Signature of F	uneral Service Li	cansee			ress of Facility Lee					
	40244	· Cu	lli 1	C. Vat	tu		ia Ferry I			aryla		
0		23a, Part1, Enter shock, or her	the diseese, or c art failure. List o	omplications that car only one ceuse on each	used the death. Do ch line.	not enter the mode of d	lying, such es cardia	c or respiratory a	arrest,	!	Approximate Interval Between Onset end Deeth	
N	Physician / /Medical	Immediata Cause	/Final	ME	TACT	ATIC	CARC) NO	MA	1	Onset and Death	
yr T	Examiner	disease or condition resulting in death)	on	a. V C	111 >1	ATIC	CVIOLE	11001	/			
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	icate be executed physician and s the burial-transit			b. [V] 1)	01410	0 1 7 0 1	1100	1 /	7	1		
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m m	clan: The law requires that the death cer entificate has been signed by the attendin sclor, page 2 should be detached for use Be Completed by Physician/N	Pert II. Other signi	ficant condition	s contributing to dea	th but not resulting i	n the underlying cause	given in Part I.	23b. Dld	I tobacco uaa c	ontributs 1	to the cause of death	
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. 5	ires that signed b	-								_	/	
) i	The law requires sign page 2 should be Completed by							24a. Wa: perf	s an eutopsy formed?	91	Vere autopsy findings vaileble prior to	
0	has be pe 2 sh									0	completion of cause of death?	
/ /	The le page page							10	Yes 20 No	1	☐ Yes 2☐ No	
N E	ysician: The is certificate director, pag	25. Wes case refe examiner?	rred to medicat		,		26. Placa of De	ath (Check only	one)			
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2	aling Ph After th funeral	27. Menner of Dee	th 5 Pending	28e. Date of (Month)		Time of 28c. tn		28d. Describe	how injury occu	rred		
0	tandi death. tor: A / the fr	2 ☐ Accident 3 ☐ Suicide	investiga	the			☐ Yes 2 ☐ No	00/ 1	(O)	1 2		
Division of	or Att	4 Homicide	determin	ad Zoe. Flace	of Injury - At home, fa g, etc. <i>(Specify)</i>	arm, atreet, factory, offic	> 9	City or To	(Street and Nurr own, State)	ber of Hui	rei Route Number,	
0	ours a control of the	00a 0-49	*	Dhualala T		4 - 4	Aim and a second				atatad	
	the Hospital or Attanding Pinn 24 hours after death. The Funeral Director: After the funeral pinner of the funeral dedical Certification:	29a. Certifier (Check only one) 29a. Certifier (Check only one) 20a. Medical Examinar: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the ceuse(s) end menner as stated. 20a. Certifier (Check only one) 20b. Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated.										
	平之声: 1	29b. Signeture end titleral cardities 29d. Date signed (Month, Dey, Year)										
	2728	De Comments Ml D27144 9-22-2000										
	1/2/	30. Name and add	ress of person w	no completed cause	of death (Item 23a)	(Type Print)	0	1	N 40	~	0	
		0.2	ATIC	2 AAAT	A	111)	('.	INI	one	/ Y\	1)	

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth Wah Month Sept 25 645 PM Jan lan 2000 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, giva street and number) 4c. County of Death Deaton Specialty Hospital Baltimore If Undar 1 Yaar If Undar 24 Hrs. Hours Min. 5. Sociel Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 1₩ 2□ F Months Deys 30 Yrs. 577 92 6112 Dec 9, 1969 Washington DC Usual Residence of Decadent 10h Count 10c. City. Town or Location 10d. Inside City Limits XX Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 601 S. Charles Street 21230 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ₹ XNO If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Black, Whita, etc. Navar Married 2 Marriad 1 ☐ Yas 2 No Specify: Specify: White 3 Widowad 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working lite. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Conrad L. Waby Judith M. Hansel 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 9213 Dandelion Lane, Upper Marlboro, Maryland 20772 Conrad L. Waby/Father 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel XMCremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Lee Crematory Sept 30, 2000 Clinton, Maryland 21. Signature of Funerel Sarvice Licansee 22. Name and Address of Facility Lee Funeral Home, Inc6633 Old Alexandria Ferry Road, Clinton, Maryland 20375 23a. Perf1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Cause (Final disaese or condition resulting in death) 5 Minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequança of) Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Encephologathe 24b. Were eutopsy findings aveilable prior to disorder 24e. Wes an eutopsy Del DICE completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospital Hospital: 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

MD

Director

Funeral

h

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health and Mental thypiene. Important: if item 27 is merked other than "natural", or items 23a or 28a-f show withjury or other traumetic event, the Med on Examiner must be incited at once.

Baltimore, Maryland 21215-0020

lcien and buriel-transit

Examiner 88 950

27. Menner of Death

1 Naturel

2 ☐ Accident

3 ☐ Sulcida

29a. Certifier (Check only

4 Homicide

29b. Signature and title of certified

physicien at the bunel Box 68760. Physician/Medical signed by the a Division of Vital Records, P.O. p Completed has Be 0 funeral Certification: After Attanding death. or Attand efter death Director:

Hospitai To the Hospital within 24 hours To the Funeral C

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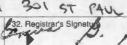
31. Dete filed (Month, Day, Yeer) SEP 2 9 2000 Registrar

Medicai

MD 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 301 57 MESHUMM

5 Pending Investigation

6 Could not be determined



28e. Dete of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

SUITE GOS

28c. Injury et Work?

🔯 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) end manner stated.

29c. Licansa number

D38675

1 Yes 2 No

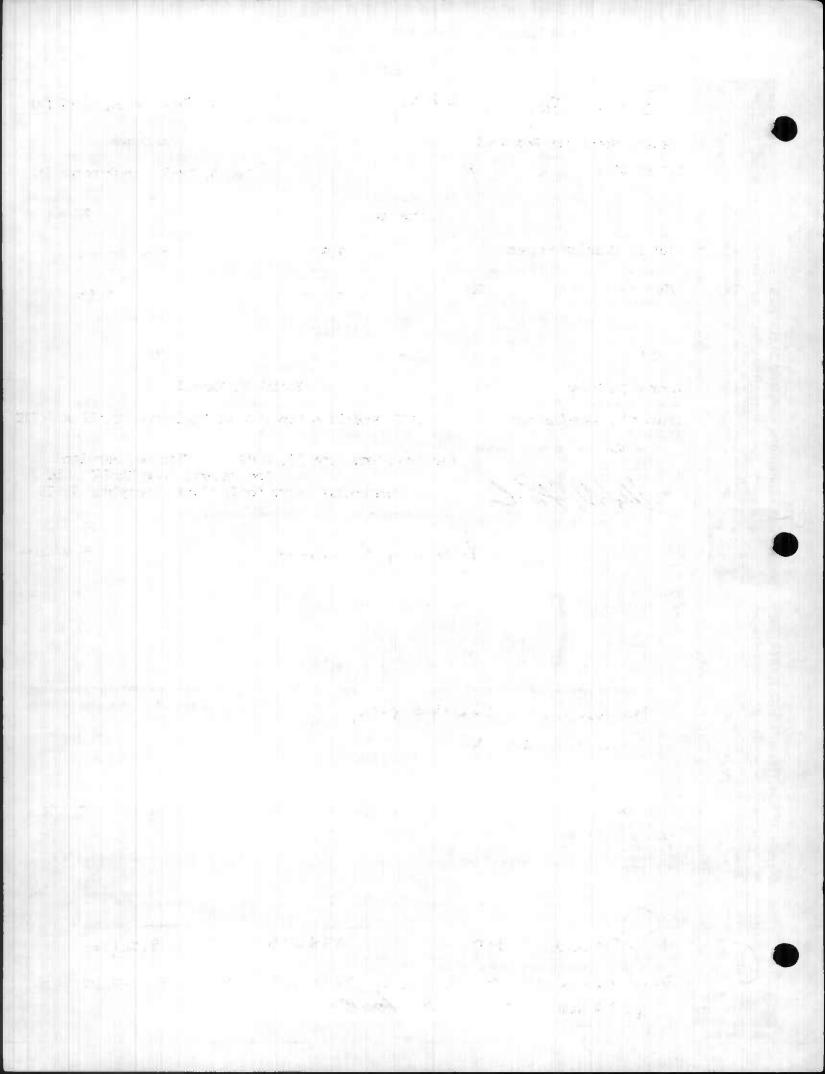
28d. Describe how injury occurred

BALTIMORE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Day, Year)

2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month 09 27 2000 0120 AM Raymond Ray Ward 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yaer) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (Stata or Foraign Country) M.d.

District Heights

Custodian

10f. Zip Code

20747

1 Yes 2 No Specify:

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.)

85 Yrs.

10c. City, Town or Location

District Heights

10d. Insida City Limits

1 ☑ Yas 2 ☐ No

May 15, 1915

18. Mother's Neme (First, Middle, Meiden Surneme)

Eliza Hawkins

19b. Malling Address (Straet and Number or Rural Route Number, City or Town, Stete, Zip Code)

2160 County Rd. District Heights, Md. 20747

10g. Citizen of What Country?

United States

16b. Kind of Business/Industry

14. Race - American Indian, Bleck, White, etc.

Specify: Black

United States Gov't

20c. Location - City or Town, State

1 € M 2 □ F

12. Was Decedent Ever in U,S. Armed Forces?

College (1-4or 5+)

1 ☑ Yes 2 □ No If Yes, Give Year or Datas: 1942/45

Physician /Medical Examiner **Funeral** Director

579-10-6662

Usual Residence of Decedent

2160 County Rd.

1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informent's Name/Relationship (Type, Print)

Louise Wright Ward/ Wife

Jeremiah Ward

10e. Street and Number

11. Marital Status

10b. County

Maryland Prince George's

15. Decadent's Education (Specify only highast grada completed)

10a. Stata

Director

p

Completed

the Marylend r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at deeth filed within nd Mental Hygiene. marked other than permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe eny injury or other treumatic event, bnce.

Physician /Medical Examine

be executed physician and s the buriel-trens Box 68760. Records, P.O. 6 this After this Director: A within 24 hours efter To the Funeral Direc completely filled in by ŏ

20b. Placa of Disposition (Neme of cemetery, crematory or othar plece) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland States Veterans 10/5/00 Cheltenham, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Alexander S. Pope Funeral Homes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 5538 Marlboro Pike/Forestville, Md. 20747 Approximata Interval Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) days Examiner obstructive ling alrease Kars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated avents resulting in death) Last Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown acete en chronic real facture, Coronary by 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed? Completed artery clisease, typertension, Sick completion of causa of death? Smus Synds. Stp permanent pace males 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospitel: 1 Ninpatiant 2 ER/Outpatient 3 DOA 1□ Yes 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) P 27. Manner of Death 28b. Time of 28d. Dascribe how Injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 1 Netural 2 Accident 5 Pending 1 Yes 2 No Invastigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, streat, factory, offica building, etc. (Specify) 4 Homicide 1 M Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. edical (Check only 29d. Data signad (Month, Dey, Year) 29c. Licanse number 29b. Signature and title of cartific

no

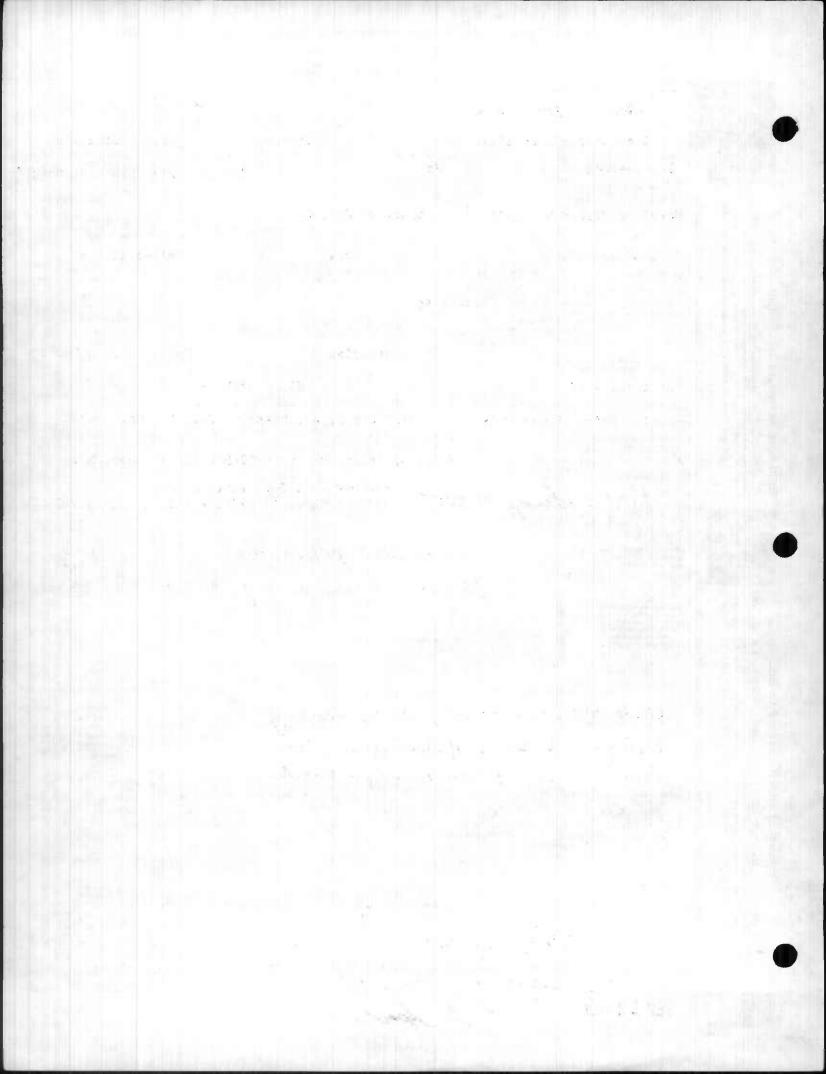
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAVINDER K. Reistagi m.D.

024720

heverly mod 20 755

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certificate of	Death	Reg. No	.00 3	2333				
	Dhusisian	Decedent's Nama (First, Middle, Last)	S. Misley		2.	Date of Death Month Da	v Year	3. Time of Death				
	Physician /Medical	MINNIE WILLIAMS				SYPT MUSER		8.15 M				
	Examiner	4a Facility Nama (If not institution, give street			4b. City, Town, or Local		. County of Death					
		Doctors Community H 5. Social Security Number 6. Sex		est hirthday) If Under 1 Year	Lanham If Under 24 Hrs. 8		rince Ge					
	Funeral Director	5. Social Security Number 579-30-6863 Usual Residence of Decedent	7. Age (In yrs. II	Yrs. Months Days	Hours Min.	Date of Birth (Month, Day, Year)	27.4	place (State or Foreign ntry) ginia				
Year	No.	10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits				
Ma.	otor oto	Maryland Prince Georg	ge's For	t Washington			1 Yes 2 □ No					
6	be notified Director	10e. Street and Number		10f. Zip Code	MEIN IN LA	10g. Cit	10g. Citizen of What Country?					
6		6801 Bock Road		20744		U.	S.A.					
90 14	iner mast iner mast Funeral	An	as Decedent Ever in U, med Forces?	S. 13. Was Decedent of 1 If Yes, specify Cub	Hispanic Origin? (Specif van, Mexicen, Puerto Ric	y Yes or No- can, etc.)	 Raca - Amaric Black, White, 					
21215-0020 d within 72 hours after	by by	H)	1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Ye Yaar or Datas:		Specify:		Specify: Blac	ek				
1 2	over then "natural, the Medical.	15. Decedent's Education (Specify only highest grada comp	pation during most of working ad)	16b. K	ind of Business/In	dustry						
121 within	d d		llege (1-4or 5+)									
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Maryland	marked off matic ever To Be	Linwood Taylor			Patsy Di		iden Sumame)					
J. Sold		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta										
M Z	27.15	Andrew Chance/Son	1									
ere,	Itam other	20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State										
Page 9	MATE IN CO.	1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1X Burial 2 Cremation 3 Removal from State Harmony Memorial Park 2000 Landover,										
altimore	portar y Inju	21. Signature of Funeral Service Licensee		22. Name and Addre	ess of Facility		lover, Ma	aryrand				
00 82	FEE	Nous A. P.	rantie		INS FUNERAL			1 00705				
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Exa	aminer	resulting in death) a	Dua to (or	as a consequence of): ive heart								
8	in in	a b	Congs	tive heart	Johinne			days				
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90,	buris buris	Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Cause (Disease or Injury that initiated evants	*	Morrowan				1~11				
68760, tificate be e	g physicia as the bur	resulting in death) Last Dua to (or as a consequence of):										
-												
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P.O.	ache ache			iting in the underlying couse gr	VOIT NI F CIT I.	1 Yes 2	4	bably 4 Unknown				
S the	be del	annouse mell	rws				4					
Division of Vital Records, P.O. Box or Attending Physician: The law requires that the death certain after death.	been s should	diobetie melli Renal insept	wency			24a. Was an auto performed?	av	fere autopsy findings railable prior to empletion of ceuse death?				
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ita	octor. p	25. Was cese referred to medical			26. Place of Death (6							
f <	his cert direct	axaminer? 1 Yes 2 No Hospita	l: 1 Inpatient 2 🗆 E	R/Outpatient 3□ DOA Ot	hor	5 Residence	8 Other (Speci	fy)				
0 4	neral neral	27. Manner of Death 1 Natural 5 □ Pending 28a		28b. Time of 28c. Injury Wo	ry at 28d	d. Describe how inju	ry occurred					
SiO	he fu	2 Accident Investigation			Yas 2□No							
V Am	Irect In by	3 Suicida 6 Could not be determined 28e	Place of Injury - At hor building, etc. (Specify,	ma, farm, street, factory, office	28f	Location (Street at City or Town, State		al Routa Number,				
C last	5 E S											
Hosp A ho	To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Completely and the complete of the com	(Check only 2 Medical Examiner: Or	the besis of axaminati	rledga, death occurred at tha ti on and/or investigation, in my	ma, data and place, and opinion, daath occurred	due to tha cause(s at tha tima, data and) and mannar as s d place, and dua t	stated. o tha cause(s)				
the contract	Med	29b. Signature and title of certifier	d manner stated.	29c. Licen	se number	29d. Da	te signed (Month,	Day, Year)				
F 3	F 8	delivers mo			53411			44 2000				
	0	30. Name and address of person who complete	d cause of death flow									
	6)	JC Musadni mo,		mitchellville	Rd # 103	Bome	CM C	20708				
	State Registrar	SEP 2 6 2000	2. Registrar's Signat	G. Local								
	3.0	DEL M O TOOO	1	. Beekal								

00-5384-033 jhm IVAN WIGGINS

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State of Maryland / Department of Health and Mental Hygiene

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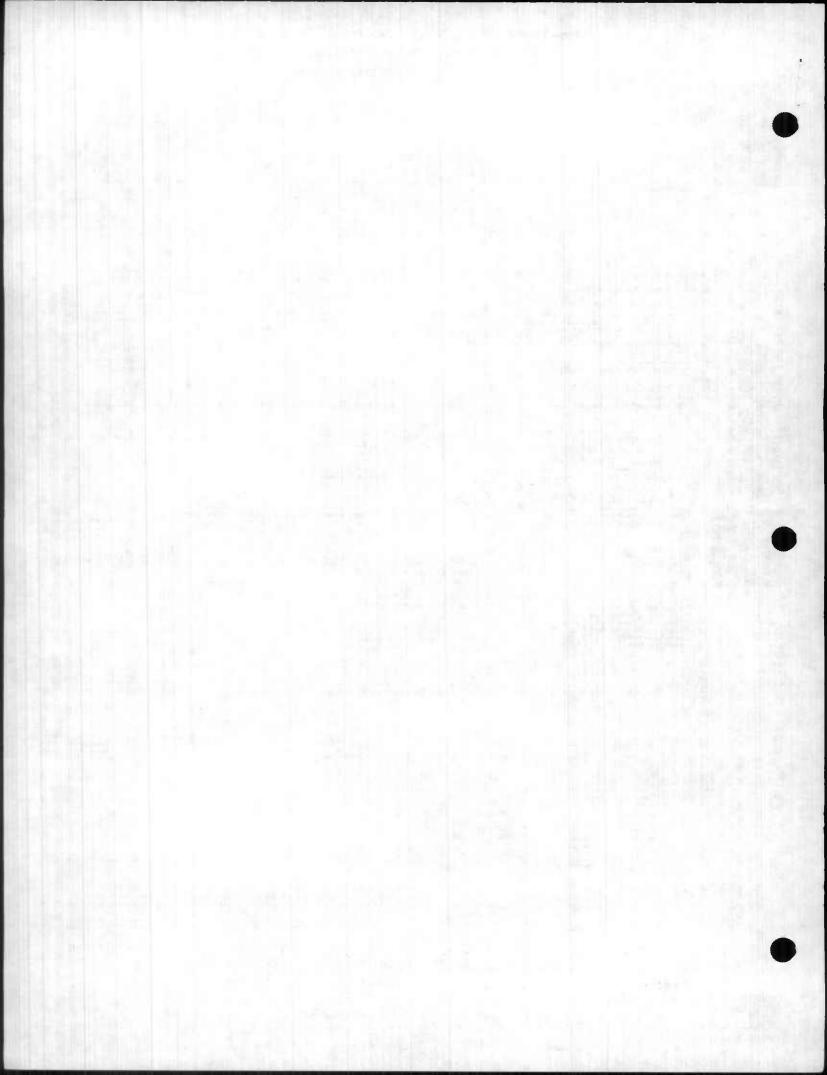
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Physician /Medical	TVan Kolando Wiggins SEPTEMBER /3 /OUU DRI // AM											
Examiner	4e Fecility Neme (If not institution, git PENNSYLVANIA AV		YSIDE A	VENUE	4b. City, Town, or I Suitland		4c. County o	f Deeth E GEORGES				
Funeral Director	579-02-3692	Sex 1≦M 2□F	rs. lest birthday) 22 Yrs.	If Under 1 Yeel Months Deys		8. Dete of Birth (Month, Dey March	Year 1978	9. Birthplece (State or Foreign Washington, D. C				
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uneral Director	Maryland Prince (City, Town or Lo Forestvi					10d. Inside City Limits 1 Yes 2 No				
F	10e. Street and Number			10f. Zip Code			0g. Citizen of Wi					
D	8400 Lenaskin Lr	n.		2074	47	1	tates					
Funer	11. Meritel Stetus 1 ☑ Never Merried 2 ☐ Married	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No			Hispenic Origin? (S ben, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- American indien, , White, etc.				
by	3 □ Widowed 4 □ Divorced	If Yes, Give Yeer or Detes:	1□Yes 2ĂNo	Specify:		Specify:	Black					
	15. Decedent's E (Specify only highest gr	ducation	16a. Decedent's Usuel Occupation				16b. Kind of Bus	iness/Industry				
Completed	Elementery/Secondery (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire			King						
į	12	College (1 40/ CV)	Sec	Security			Privat	е				
	17. Father's Neme (First, Middle, Last	1)			18. Mother's Ner	18. Mother's Neme (First, Middle,)				
o Be	Carl R. Wiggins				Iris Z	eigler						
ī	19e. Informent's Neme/Reletionship	(Type, Print)	19b. Mailir	ng Address (Stree		elgler ural Route Number, City or Town, Stete, Zip Code)						
	Iris Zeigler / M		8400	8400 Lenaskin Ln. Fo			Md 21	77/7				
	20e. Method of Disposition					Date		City or Town, State				
	20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) Washington National Cem. 9/28/00 Suitland, M. 21. Signeture of Funerel Service Licenses											
	Kutha. L	tunger MIDI	ACT !	Alexande 5538 Mar	r S. Pope	e Funeral	. Homes	Md. 20747				
	23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 5538 Marlboro Pike/Forestville, Md. 20747 Approximate finterville Between Onset end Death											
Examiner	Immediate Cause (Finel disease or condition resulting in death) e. Hourd Injuries Due to (or es e consequence of):											
	Sequentielly list conditions, Due to (or es e consequenca of): if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury c.											
n/Medicai	thet initiated events resulting in death) Lest Due to (or es e consequence of):											
Physicia	Pert II. Other significant conditions of	contributing to death but not r	esuiting in the u	nderrying cause g	iven in Perti.	23b. Did tobacco use contribute to the cause of						
2			- 19									
Completed						24e. Wes e	en eutopsy med?	24b. Were eutopsy findings available prior to completion of cause of deeth?				
Eo						191	es 2 No	1 Tes 2 No				
	25. Was case referred to medical				26 Place of Dea	ath (Check only or	ne)					
	examiner? 1X Yes 2 No	Hospitel: 1 Inpatient 2	DEB/Outpation	nt 3 DOA O	thor-			(Specify) SCENE				
	27. Menner of Deeth	28a. Date of Injury	28b. Time of	IL SEL DON	4 La radiality f		ow Injury occurre					
	1 □ Naturel 5 □ Pending 2 Ø Accident Investigation	on 4-23-00	001E	W	ork? □Yes 2万No	ans.	- hred o	object coleision				
within 24 hours after death. To the Funeral Director: After toompletely filled in by the funer. Medical Certification:	3 Suicide 6 Could not be determined	building, etc. (Spe	t home, ferm, str ocify) (uu	eet, fectory, office		28f. Location (S	itreet and Numbern, Stete)	r or Rurel Route Number,				
edical C	(Check only 2 Medical Example 1997)	hyercian: To the best of my k miner: On the besis of exami	nowledge, deeth					ner es stated.				
Med	one) A	and menner steted.										
E	29b. Signature end title of cartifier	1961		OCIV	ise number IE			(Month, Dey, Year) ER 23, 2000				
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)											
	David R Fowler 111 Penn Street, Baltimore, Maryland 21201											
tate	31. Dete filed (Month, Day, Year) Registrer's Signeture											
jistrar	SEP 2 6 2000	1	1.	apour								

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State of Maryland / Department of Health and Mental Hygiene 00 323

			C	ertifica	ate of	Death		Reg. No.	32333	
Physician	1. Decedent's Name (First, Middle, Las-						2. Date of Dec Month	ath Day Year	3. Time of Death	
/Medical	Lula Osborn						Sept	19, 2000		
Examiner	4a Facility Name (If not institution, give					4b. City, Town, or				
	815 Clearview Ave		rs. last birthd	au) If Und	ler 1 Year	Hampst		Carro		
Funeral Director		M 2XF 88	Yrs	Month:					irthplace (State or Foreign Country) st Virginia	
M M	10a. State 10b. County	10c.	City, Town or	Location			71111		10d. Inside City Limits	
Man filed.	Maryland Carro	011				Hampste	ead		1 ☐ Yes 2 ☒ No	
er death with the Maryland thems 23e or 28e+ show ner must be notified at uneral Director	10e. Street end Number 815 Clearview Ave	enue		101. 2	Zip Code	21074		10g. Citizen of What Country? USA		
by F	11. Merital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever In Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:	n U,S. 1		cedent of I becify Cub 212 No	Hispanic Origin? (S van, Mexicen, Puer Specify:	specify Yes or No to Rican, etc.)	14. Race - An Black, Wi Specify:	nerican Indian, nite, etc. White	
72 ho	15. Decedent's Edu (Specify only highest grad	ucetion de completed)	16a. De	cedent's Us	ual Occu	pation during most of wo d)	rking	16b. Kind of Busines	s/Industry	
The state of the s	Elementary/Secondary (0-12)	College (1-4or 5+)	`lif					Own Ho	me	
led within hygiene. her than n. the Men. Compl	3			Hous	sewif		ma (Final Middle	Meiden Sumame)		
Be sver	17. Fether's Name (First, Middle, Last) Garrett Osborn						etlock			
To To	19a. Informant's Name/Reletionship (T	ima Print)	10b 84	ailina Addra	ee /Straa	t end Number or Ri	Zin Code)			
Ma d 2 s The s Trans	Arthur Ward, son	ype, riini)				5, Hamps			, 210 0000)	
Te, 1 and Head of the state of	20a. Method of Disposition	20	b. Plece of Di	sposition (N	lame of		Date	20c. Location - City	or Town, State	
baltimore semit. Pages 1: Department of He mportant: If ther try injury or oth	1 Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify	cemetery, of Sams C	crematory of	s, MD						
mit. P	21. Signature of Funeral Service Licens		Sallis C			ess of Facility	9/22 Eline F	Funeral Hor		
D SOLUTION OF	1 X trever	19/1		93	4 Soi	uth Main		ostead, MD		
Physician /Medical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	. Chronic Ob		ive F	hlmo				Approximate Interval Between Onset and Death	
the attending physician and the for use as the burial-transit bysician/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	00 7								
ath certificate be exact certificate be exact to use as the burial clan/Medical Ex	resulting in death) Last	Due to (or as a consequence of):								
the death cer y the attendir sched for use	Part II. Other elenificant conditions co	contributing to death but not resulting in the underlying ceuse given in Pa					art I. 23b. Did tobacco use contribute to the cause of			
d by estace				102	2 No 3	Probably 4 Unknown				
The law requires that the death cer the law requires that the death cer page 2 should be detached for use Completed by PhysicianA								an autopsy 24	Were autopsy findings available prior to completion of cause of death?	
The law ate has page 2							10	Yes 2 No	1 ☐ Yes 2 ☐ No	
ystelen: The s certificate director, pag	25. Wes case referred to medical					26. Plece of De	ath (Check only)	one)		
- K S D	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ☐ ER/Outpa	itient 3	DUA		Home 5 Resi	dence 6 □Other (S	oecify)	
tor Attending Physician: T affectoeth. Director: Affer this carificat din by the funeral director, p. ertification: To Be C.	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Yea.	28b. Tim Inju		28c. Inju	rry at ork?] Yes 2 ☐ No	28d. Describe	how injury occurred		
\$ 5 m 0	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm ecify)	, street, fact	ory, office		28f. Location (City or To	Street and Number or wn, State)	Rurel Route Number,	
Ne Hospital n 24 hours ne Funeral pletely filled		elclan: To the best of my Iner: On the basis of exam and manner stated.								
within To the comple	29b. Signature and title of certifier 29c. License number 29d. Dete signed (M								onth, Day, Year)	
	Der main o	DI	2901		9/20/	2000				
	30. Name and eddress of person who c		Item 23a) (Ty					//		
	Deogracias V. Faus	tino, M.D.	4111 I	. Bec	kley	sville Ro	Hampste	ead, MD 210	074	
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature SED 2 5 2000 32. Registrar's Signature									

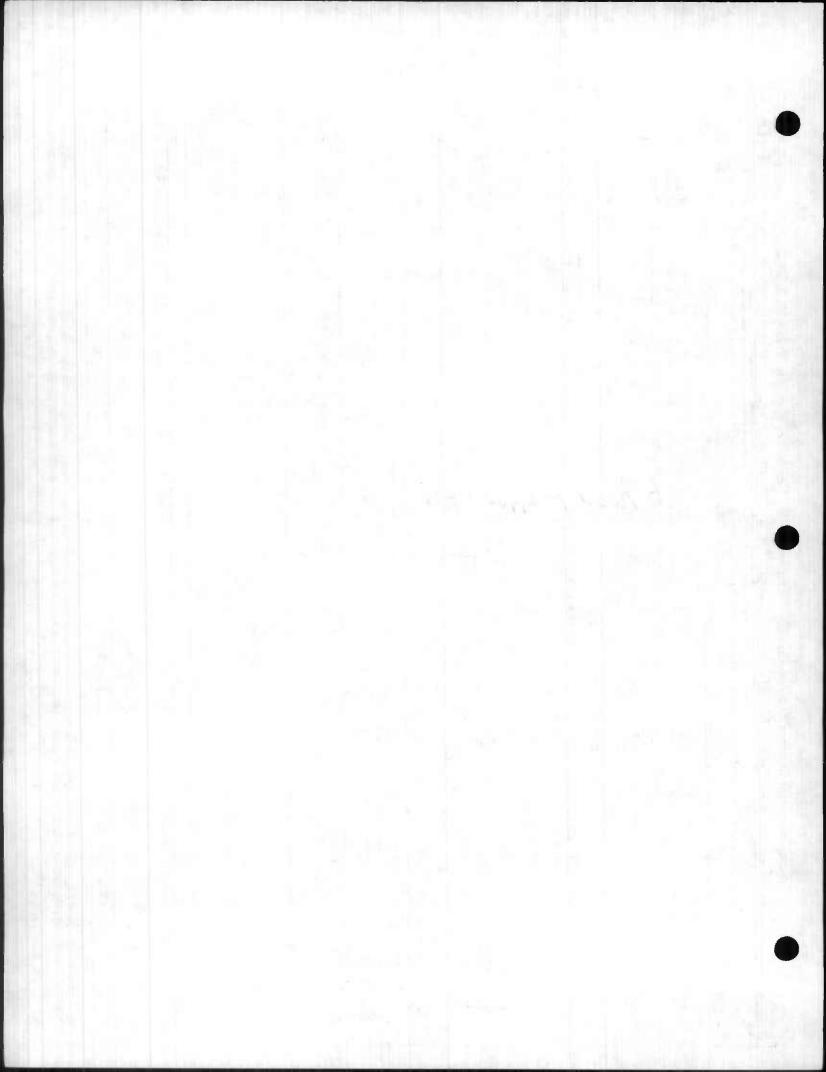


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State of Maryland / Department of Health and Mental Hygiene

al Hygiene	0	0	3	2	3	3	E
Reg. No.				4-40			

				Certifi	cate of	Death		R	leg. No.			
	1. Decedent's Name (First, Middle	a, Last)			T-h		100	2. Deta of Dee		M	3. Tima of Death	
Physician	GEORGE WIN	FIELD V	WILLIAMS,	SR.				Sept.	22,200	OÇar	9:05 PM	
/Medical	4e Facility Nama (If not institution			DIC.	1	4b. City. To	wn. or Loc	ation of Death	4c. County			
Examiner	Salisbury Center; Genesis ElderCare Salisbury, Md. Wicomi											
	-			1 447		If Undar	-					
neral	5. Social Security Number	6. Sax 1 ⊠ M 2 □ F	7. Age (In yrs. last	Mo	Undar 1 Yaer	Hours	Min.	8. Data of Birth (Month, Day	Year)	Birthplace (Stata or Foraign Country)		
ector	220-01-7888	12210 221	82	Yrs.				JULY 26	, 1918	MARY	LAND	
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rector	10e. Stata 10b. County		10c. City, 10	own or Locatio	n					1	0d. Inside City Limi	
Ş	MARYLAND WICO	MICO	S	ALISBU	RY						1 ☐ Yas 2X N	
9	MARYLAND WICOMICO SALISBURY 10e. Street and Number 10g. Citizen of What										itry?	
	506 PACIFIC AVE				210	201			II C A			
era	11. Marital Status		dant Ever in U.S.	13 Was		304 Jispanic Ori	gin? (Spe	cifv Yes or No-	U.S.A.	e - Amaric	en Indian,	
5	Armed Forcas? If Yas, specify Cuban, Mexican, Puarto R							Rican, atc.)		k, White,		
by F							2X No Specify:				TOP	
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d	Elemantary/Secondary (0-12)	Collega (1	-4or 5+)	lifa. DO N	IOT usa ratire	d)						
5	4			OWNER	/ OPE	RATOR		RESTA			NT	
Be	17. Fether's Name (First, Middle,	Last)				18. Moths	ır's Nema	(First, Middla,	Maidan Sumam	na)		
ToB	CLAYTON L.	WILLIAMS				LAVI	INTA	L.	CORKRAN	I		
-	19a. Informant's Name/Relations		1	19b. Mailing Ac	idrass (Street				r, City or Town,		Code)	
	JOSEPHINE M. WI			506 PA					MD 218			
		LLIAMS		of Disposition		AVE.	SAL	Date Date	20c. Location -		State	
	20a. Mathod of Disposition		Date	20C, Location -	City of To	own, Stata						
	1 National 2 Crametion 3 Ramovel from State 4 Donetion 5 Other (Specify) camatary, crematory or other place) WICOMICO MEMORIAL PARK 9/26/00 SALISBU									JRY,	MARYLAND	
4	21. Signature of Funeral Sarvice Licensee 22. Nama and Address of Facility 705 E. MAIN ST.											
puce	B. Read Physics, CFSP BOUNDS FUNERAL HOME, INC. SALISBURY, MD 218											
	12 Dely	hyper	N, UFS							BURY		
	23a. Part1. Entar tha disaase, or shock, or haart failure. List	r complications that cannot only one cause on a	aused tha deeth. Dech line.	o not antar the	a moda of dyli	ng, such es	cardiac o	r raspiratory ar	rast,	1	Approximata Intarvel Batween	
ian	The second second	,	2		9-0-1					1	Onsat and Death	
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Be Completed										of	death?	
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BeC	25. Was cesa refarred to medice					26. Plece	e of Death	(Check only o	na)			
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5	1 Natural 5 Pandie		of Injury th, Day Year)	Injury	28c. Inju				,,			
cat	2 Accidant Investi			ľ	A 1	Yas 2□						
Certification:	3 Suicide 6 Could datern	nined 268. Place	of Injury - At homa	, farm, street,	lactory, office		2	28f. Location (S City or Tox	Street and Numb m, Stata)	ber or Run	al Route Number,	
9	4 ☐ Homicida building, atc. (Specify) City or Town, Stata)											
-	29a. Certifiar 12 Certifyin	ng Physician: To tha	best of my knowled	dge, daath occ	urred at tha ti	ma, deta ar	nd plece, a	and dua to tha	ausa(s) end me	enner es s	stated.	
20		Examiner: On the ba										
Medical Certi	1		iai stated.		20a Hann				20d Data signs	d /Month	Ony Vaerl	
-	255.55									ia (month),	Day, real)	
0	1 / May MD D 39813 9/25								21	(0)		
1	30. Name and addrass of person who completed causa of daath (Itam 23a) (Type, Print)											
	MATKINS MUS 1104 HEALTHWAY DR., SALISBURY, MD 21804											
	21 Date filed (Manth Court Vacci	30 0	agistrar's Signeture		LAWAI	DK.	DALLE	DOKI! I	אר אר	10 -1		
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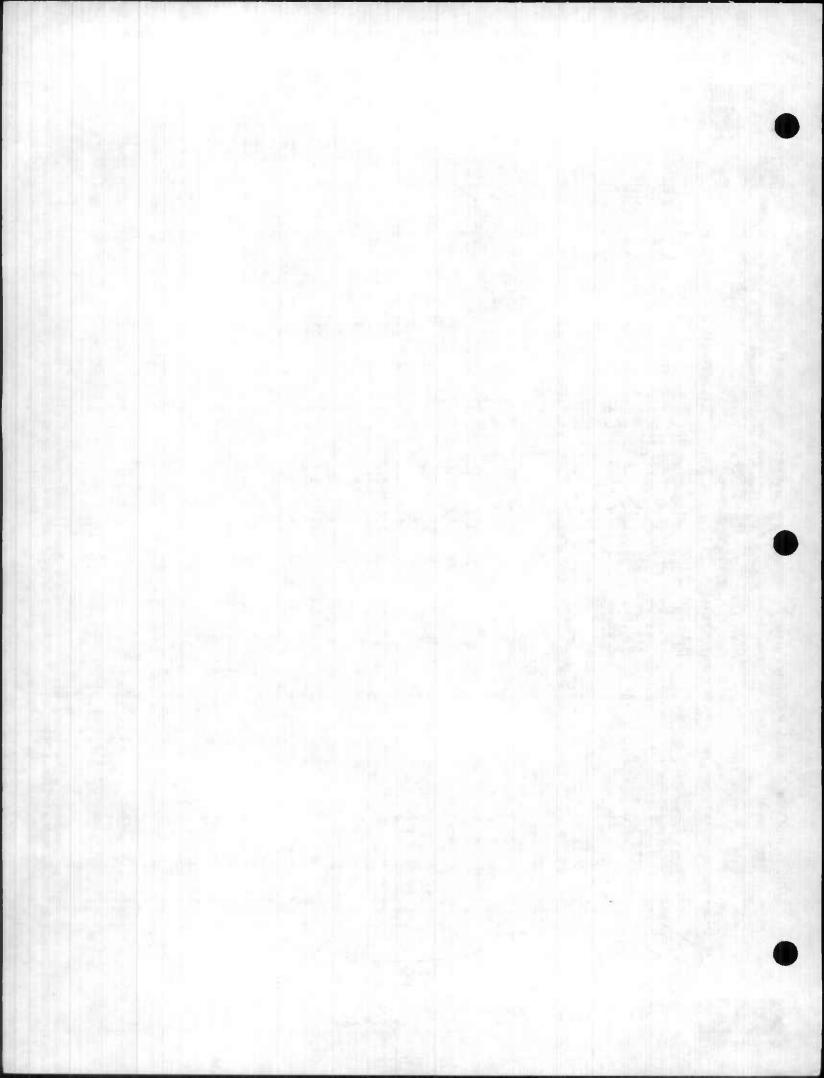


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State of Maryland / Department of Health and Mental Hygiene

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					Certifica	ate of	Death			Reg. No.		02001
		1. Decedent's Neme (First, Middle, La	st)						2. Date of De		M	3. Time of Death
	ysician	HELEN FF	ANCES	YOWEL	L				Septem	ber 22,	2000	6:15 PM
	Medical	4e Facility Name (If not institution, gh	re street end number)				4b. City, Tox		ation of Death			
	kaminer	506 Washington S					Salid	sbury		TAT-	i comi	-
		5. Societ Security Number 6. S		e (In yrs. last bir	thday) If Un	der 1 Yee			8. Date of Birl (Month, De		1 COM1	
	neral ector				Yrs. Month	hs Deys	Hours					elace (State or Foreign
Dire	-0101	Usual Residence of Decedent					1		November	20,1918	Ma	ryland
Die B		10a. State 10b. County		10c. City, Tow	n or Location						1	0d. Inside City Limits
9 5	ar death with the Maryla thems 23s or 28s-f shor oer must be notified at uneral Director	Maryland Wicomi	CO	Sali	shurv							1√ Yes 2 No
25 th	be notified Directo	10e. Street and Number							10g. Citizen of Whe			atry?
23a or 28a-f	ral Dir	506 Washington	Street			218				USA		
65 6	foer must	11. Maritel Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Wes De	cedent of pecify Cul	Hispanic Orle ben, Mexican	gin? (Spec	cify Yes or No lican, etc.)	- 14. Raci	e - Americ k, White,	
	Exams by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Detes:	No	1□ Yes	2 X No	Specify:			Specify	. Wh	ite
Maryland 21215-0020 d 2 about be filed within 72 hours at th and Mental Hygiene.	r, the Medical Completed	15. Decedent's E (Specify only highest gr	ade completed)		Decedent's U (Give kind of life. DO NO	suel Occu work done	pation during most	t of workin	g	16b. Kind of Bu	isiness/Inc	dustry
112 Page 1	M H	Elementary/Secondary (0-12)	College (1-4or :							Tina 1 to b		
D DEED		17. Fether's Name (First, Middle, Last			Nurse		18. Mothe	er's Name	(First, Middle,	Health Maiden Sumem		e
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Baltimore semit. Pages 1. Separtment of Hammoortant; If Hem	ury or of	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donetion 5 Other (Special Control of Control o	Removal from State (y)		f Disposition (in ry, cremetory of the Memory)			9,	Date /26/00	Salis		
Balt permit. Departr	eny in	21. Signature of Funeral Service Lice). n	0 == 0	Holl	oway	ess of Facilit Funera	al Ho	me Pro	fessiona ury, MD	al As	sociation
91		23e. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	d the deeth. Do								Approximate Interval Between Onset and Death
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	i i	resulting in deeth)		Due to (or as e	consequenca	of):						
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death o	etached for us Physician								1			
0 8 8	ched	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	n the underlyin	g cause g	iven in Part I.					o the cause of death?
O 1 2 2	be detached by Physic					E.)) E.			10	Yes 2⊠No	3∐ Proi	bably 4 ☐ Unknown
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Vital	director,	25. Was case referred to medical examiner?						ot Deeth	(Check only	ner		
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OD O ding Ph th.	the funerel cation:	27. Manner of Deeth 1 Naturel 5 Pending 2 Accident investigation	28e. Date of Inju (Month, De	lry Year) 28b.	28b. Time of lnjury st Work? M 1 Yes 2			28d. Describe how injury occurred		red		
Division of Attanding after death. Director: After	ther different in by	3 Suicide 6 Could not be determined					2	28f. Location (Street end Number or Rurel Route Number City or Town, Stete)			el Route Number,	
To the Hospital of within 24 hours a To the Funeral D	completely filled in by Medical Certifi		nysician: To the best niner: On the basis of end manner st	f examinetion an								
o vietico	Me	29b Signature and title of certifier	_	_		29c. Licer	nse number			29d. Date signe	d (Month,	Day, Year)
FSF	P	Where)(B	46025	7		9/8	5/0	0
181	W S	30. Name and address of person who	completed cause of d	leath (Item 23a)	Type, Print) Sevice		10 0	10 11		7	1	
1010	40	31. Dete filed (Month Day Year) SEP 2000	Way Driv	er's Signeture	Serie	1,10	0001	011				
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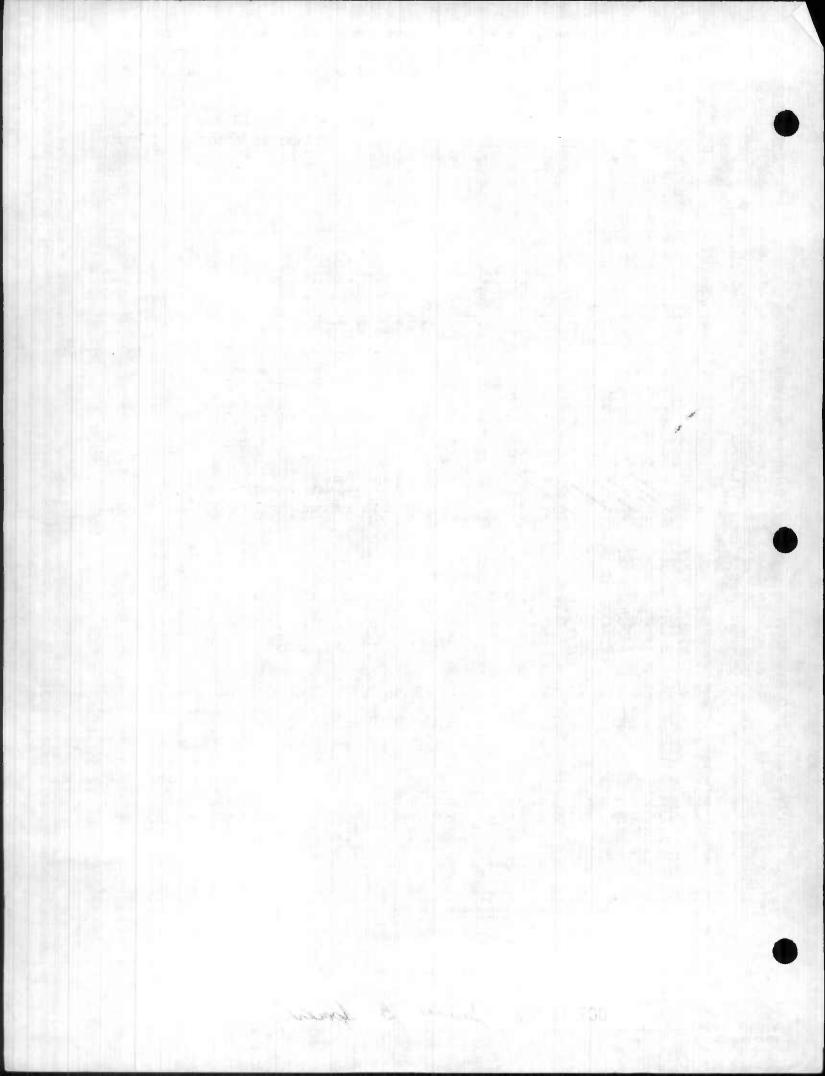


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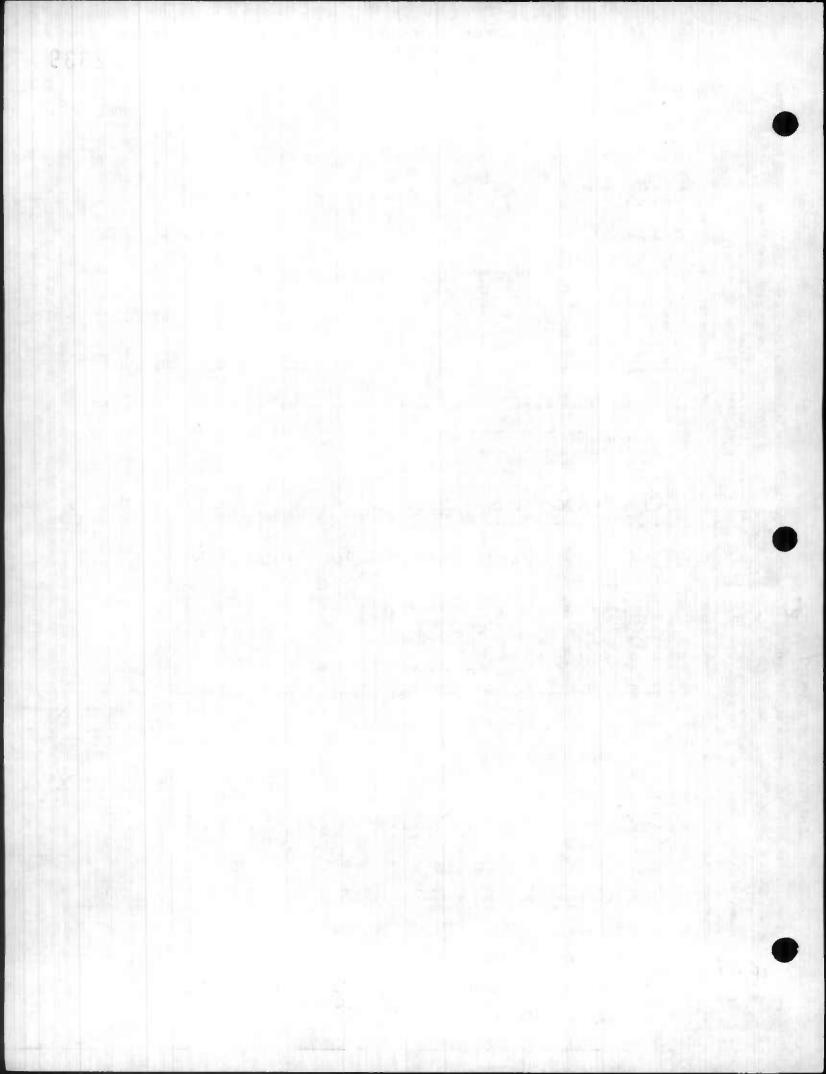
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edical miner	46	ROBERT Charles YOUNG 4e Facility Nema (If not institution, give street and number) 4b. City, Town, 0					wn, or L				of Death	1 2 . 7					
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by Funeral			rried 2∑ Mai	rried	12. Was Dece Armed Fo 1 X Yas If Yas, Giv Yaar or D	2□No	.943 13 .945	Was Dece If Yas, spo 1 Yas		lispante Ori an, Maxicar Specify:	gin? (Sp i, Puerto	pecify Yes or No Rican, atc.)	0-		ea - Amaric ck, Whita, /: Whi	etc.	
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ошо		Elementary/Se	ary/Secondary (0-12)		Collega (1-4or 5+) Letter							US Posta		tal S	1 Service		
Bec		7. Father's Nam	a (First, Middle	, Last)		SHOTA	112/4			18. Mothe	ar's Nam	e (First, Middle	, Maidan	Sumem	10)		
ToB		George	A. You	ng						Dor	othy	Daly					
	19	9a. informant's Ruth A	Name/Ralation Young		Wife)							ral Route Numb		or Town,	Stata, Zip	Coda)	
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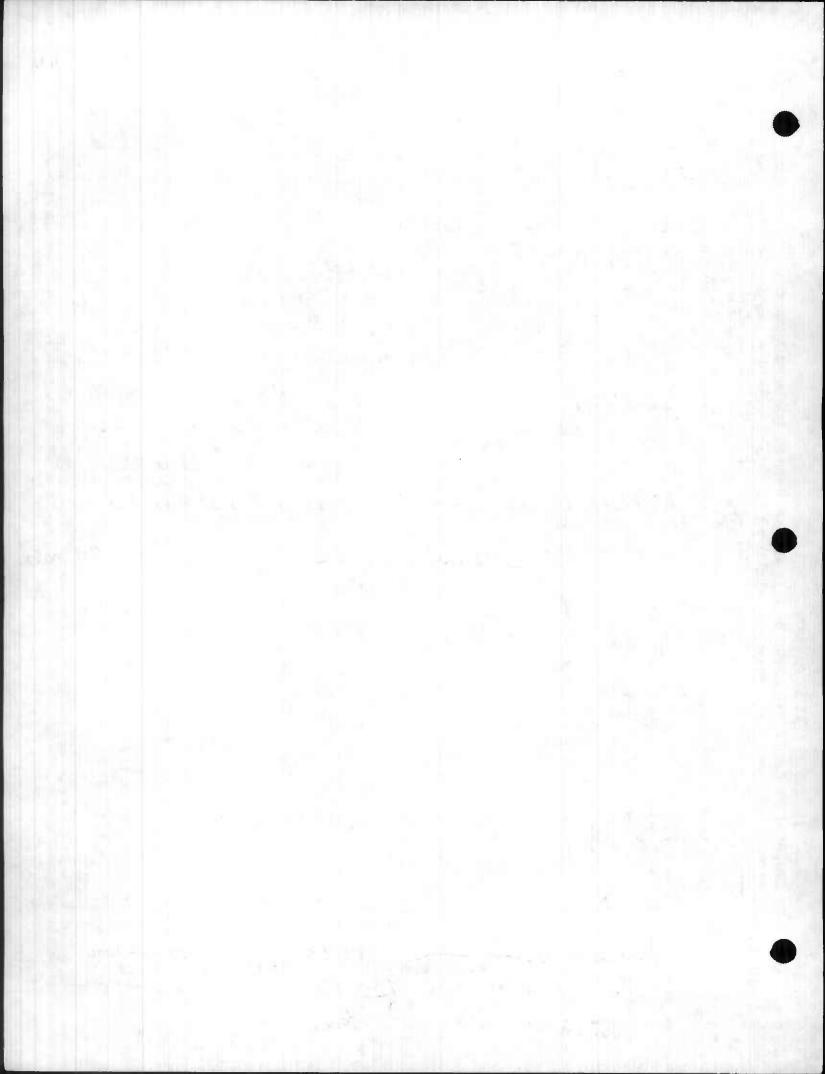
State of Maryland / Department of Health and Mental Hygiene 0 32339

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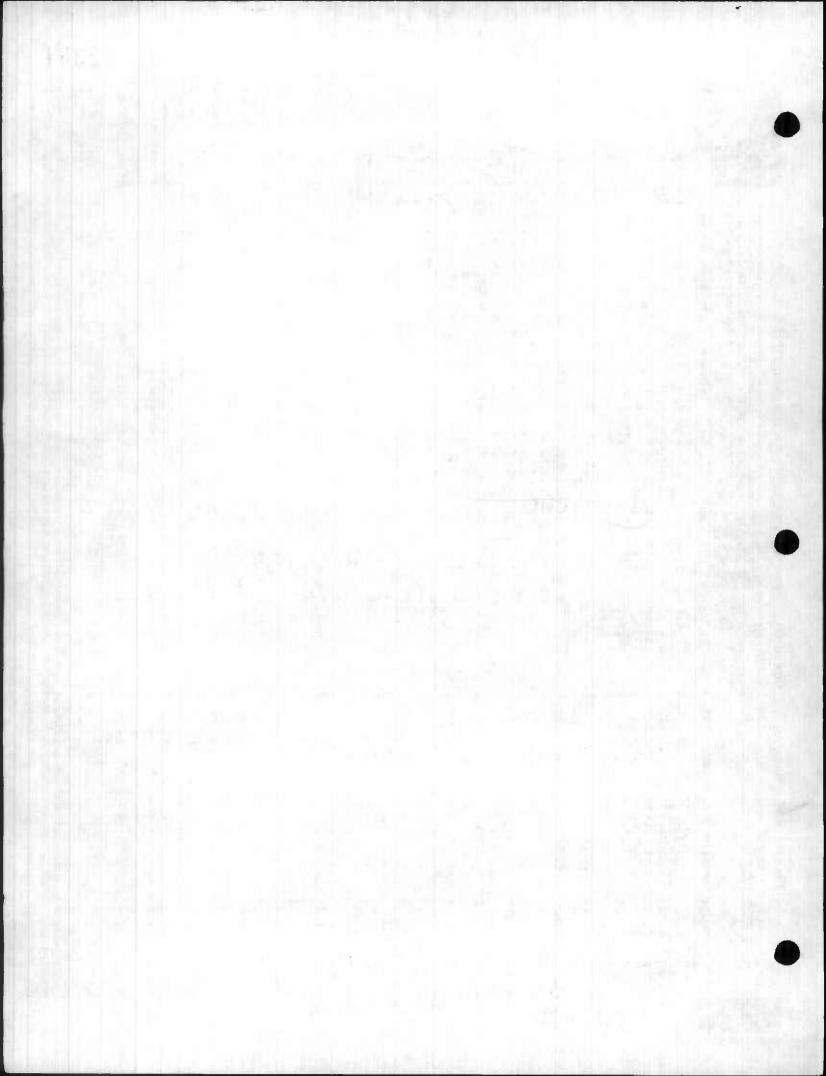
		State of Marylan		nt of Health and te of Death		leg. No.	0 32340	
Physician /Medical	1. Decedent's Nama (First, Middla, Last)	Bontloy			2. Data of Dea Month	1th Pay 2000	3. Tima of Death 1:550m	
Examiner Funeral Director	018-38-3034	treet and number) R R 7. Aga (In yrs	last birthday) If Und	ar 1 Yaar II Undar 24 Hr		4c. County of Har	Death OLD Birthplaca (Stata or Foraign Mary Jand	
anyland	Usuat Rasidance of Decedant 10a. Stata 10b. County	10c. City	y, Town or Location				10d. Inside City Limits 1 ☐ Yas 2 No	
death with the Manyland was 23a or 28a-f show must be nothed neral Director	10e. Street and Number	60 ID	el ALR 101. 2	ip Coda		10g. Citizen of Wh		
natural, or teme 23a or 28a-f show of cal Examiner must be notified at leted by Funeral Director	11. Marital Status 1 Navar Marriad 2 Marriad 3 Widowed 4 Divorced	2. Was Decedent Evar in U, Armed Forcas? 1 Yas 2 No If Yas, Give Yaar or Datas:	S. 13. Was Dec	edant of Hispanic Origin? (ecify Cuban, Maxican, Pua	Specify Yas or No- rto Rican, atc.)		Amarican Indian, Whita, atc.	
	15. Decedant's Educ (Specify only highast grade Elementary/Secondary (0-12)		16a. Decedent's Us (Giva kind of w lifa. DO NOT	ual Occupation york dona during most of with usa ratired) U OLLA	orking BR	16b. Kind of Busi	elephante	
	17. Fathar's Nama (First, Middla, Last) UNKNOWN 19a, Igformant's Name/Balationship (Ty)		19h Mailing Addra	18. Mother's Na FLO ss (Street and Number or F	Ama (First, Middla, PUNCL (Bural Bouta Numbe	E HO	Greagle	
igas 1 and 2 should it of Haalth and Mer if item 27 is marke or other traumarte	20a. Method of Disposition 1 Dispurial 2 □ Cremation 3 □ Ri	fley 206. P	9 OVER	BROOK WR.	Bolde Oct. 12	R. Md	210/4 ity or Town, Stata	
permit. Pa Departmen Important any injury and injury	4 Donation 5 Dothar (Specify) 21. Signature of Funeral Service Licenter	11 Jells	22. Nama	and Addrass of Facility &	VOUS FU	nurch relat C	VIILE, MOX hapel-Beltie Ud 21050	
Physician /medical Examiner	Immediate Causa (Final disasse or complicate causa (Final disasse or condition rasulting in death)	a causa on aach lina.	Carci	nome	ac or raspiratory ar	rest,	Approximata Intervel Between Onsat and Death 39 MOS	
that the death cartificate be executed ed by the attending physician and detached for use as the burist-transit y Physician/Medical Examiner	Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaase or Injury that initiated evants rasulting in death) Last		r as a consequance of					
that tha death cartificed by the attending prodetached for use as	Part II. Other significant conditions con	ributing to death but not rasi	ulting in the underlying	ceusa givan in Part I.	23b. Dld t	obacco uae cont	ribute to the cause of death	
es that the igned by th be detach by Phys					10	res 2000 :	3 ☐ Probably 4 ☐ Unknow	
ew requires se been s 2 should pieted						an eutopsy med?	24b. Were eutopsy findings available prior to completion of ceuse of death?	
ysician: The lew is certificata has t director, paga 2 s To Be Compi	25. Wes case referred to medical		26 Place of D	1 □ 1	(-	1 ☐ Yes 2 DANO		
Physician: this certific ral director.	TI THE ZELINO	1	ER/Outpatient 3 I	Othar	Homa 5 Rasio	lance 6 Othar		
tal or Attending Physis is after death. al Director: After this clied in by the tuneral director: Certification; To	27. Mannar of Death 1 \$\frac{1}{2}\text{ Netural} 5 Pending invastigation} 2 \text{ Accidant} 6 \text{ Could not be determined}	28a. Data of Injury (Month, Day Year)	28d. Dascribe how injury occurred 28f. Location (Straat and Number or Rural Routa Number,					
To the Hospital or A within 24 hours after To the Funeral Directomplataly tilled in b Medical Certif	29a. Certifier 1 Certifying Phys	building, afc. (Specify	y) wiedge, deeth occurre	d at the time, date and place	e, and due to the ceuse(s) and mannar es steted.			
To the Hospital within 24 hours a To the Funeral I complately tilled	(Check only 2 Medical Examin	er: On the basis of axaminat and manner steted.	tion and/or invastigation	on, in my opinion, death occ	curred at tha tima,	data and place, ar	nd dua to tha cause(s)	
To with	29b. Signatura and titla of certifiar	100	2	9c. Licansa number			(Month, Day, Year)	
D:	30. Nama and address of person who co	mpleted cause of death (Itarr	7 23a) (Type, Print)	Frank	Ito., m.	d. 212	37 Drive	
State Registrar	31. Data filed (Month, Day, Yaar)	32. Registrar's Signa		Some	79	car &		



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State of Maryland / Department of Health and Mental Hygiene 0 0 32341

	Certificate of Death	Reg. No.	00 32341		
Dhusisian	1. Decedent's Name (First, Middle, Last)	2. Dete of Death Mgnth; Dey	3. Time of Death		
Physician /Medical	Susie Blacus	October 11	, 2000 1:40A		
Examiner	4e Fecility Neme (If not institution, give street and number) 4b. City, Town, pr Lo	ocation of Death 4c. C	County of Deeth		
	Moray Hospital Bulti	NOTE			
Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year IT Under 24 Hrs. Months Deys Hours Min.	8. Dete of Birth (Month, Dey, Year)	Birthplece (State or Foreign Country)		
Director	212-30-3095 1 M & F 80 Yrs. Months Deys Hours Min.	07-17-20	VA		
מ	Usuel Residence of Decedent				
how how	10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits		
or 28a-f all per noothed	MD NA Baltimore		1 ☑ Yes 2 □ No		
r 28	10e. Street and Number 10f. Zip Code	10g. Citize	en of What Country?		
3a c	3509 Cliftmont Avenue 21213	U	SA		
72 hours after death with the Maryland natural; or items 23s or 28s-1 show deal Exeminer must be notified at eted by Funeral Director	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuben, Mexican, Puerto		4. Race - American Indian,		
Fu fier	1 Never Married 2 Married 1 Yes 2X No		Bleck, While, etc.		
urs aff	3 ☑ Wildowed 4 ☐ Divorced Yeer or Detes:	S	Specify: Black		
natural',	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind	d of Business/Industry		
5	(Specify only highest grade completed) [Secretary (Specify only highest grade completed) [Give kind of work done during most of working life. DO NOT use retired)	ing			
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正工台 5 点	17. Fether's Neme (First, Middle, Last) 18. Mother's Neme	(First, Middle, Maiden S	umeme)		
Tage m	Tom Bruce Maggie	Spence	er Randallsto		
should nd Mer marks imatic	19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rure				
0 0 0 0	Rebecca Biggers 3558 Carriage Hill				
1 and Health am 27 rther tr	20e. Method of Disposition 20b. Plece of Disposition (Neme of		ation - City or Town, Stele		
S T T	1 Rurial 2 Cremetion 3 Removal from State cemetery, cremetery or other piece)				
	4 Donetion 5 Other (Specify) Baltimore Cemetery 10-	-14-2000 Baltimore,MD			
pemit. Peg Department Important: I any Injury o	21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Ba	ltimore, l	Maryland 21202		
80 = 90	WM.C.March FH 11	Ol E. Nor	th Avenue		
	23a Part From the dipente, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec of shock or bean filling. List only one cause on each line.		Approximete		
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/Medical	Immediate Cause (Final	illi			
Examiner	disease or condition resulting in deeth) a.	ung	1		
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icata be physicia s the bu	thet initiated events				
= 00	d				
at the dasth cert d by the attendin etached for use. Physician/W					
the street hed y	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco u	ss contributs to the cause of death		
that the de ed by the detached Physic	il in certers in	1 ☐ Yes 2 ☐	No 3 Probably 4 Unknow		
requiras that been signed b should be deta eted by PI	The following		0		
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certificate rector, peg	25. Was case referred to medical 26. Place of Death		3.0		
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tal or Attanding P rs aftar death. al Director: After t led in by the funers Certification:	determined determined determined determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stele)			
P Hospital n 24 hours Funeral pletely filled adical Co	29a. Certifier Control of the basis of my knowledge, deeth occurred at the time, date and place, (Check only Check on Check only Check only Check on Che				
the H	one) end menner steted.				
within To the comple	29b. Signature and title of conflier	29d. Date	signed (Month, Day, Year)		
	1/27	O With	Her 11. 2000		
n	30. Name and address of person who complisted cause of death from 23a (Type, Print)				
10	Howterland Bolling MA Merry Hospital >	301 Sailt	Paul, Balt.MI		
State	31 Date filed (Month) Day, Year) St. Registrar's Signature	3,000	1		
Registrar	OCT 1 3 2000 Dente				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\begin{align*} \emptyset{\text{Proposition}} \text{\$\tex{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\}\exitt{\$\text{\$\texitt{\$\te Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First Middle | ast) Mostly L. 0900 08 2000 Booker James H. 4b. City. Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number, 4c. County of Deeth Deaton Specialty Home & Hosp DAHIMORE If Under 24 Hrs. 8. Date of Bir 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) Days XX 20 F Months Hours 82 218-07-5282 08-24-18 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 USA 1527 N. Washington Street 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 XMarried 1 ☐ Yes 2X Xio Specify: Specify: 3 Widowed 4 Divorced Black 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Bethlehem Steel Co NA Shipyard 7th Grade 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Annie J. Brown Booker Herbert 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 21213 1527 N. Washington Street Baltimore, MD. Booker 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State Voshell Mem. Gardens 10-13-2000 Dundalk, MD 4 Donetion 5 Other (Specify) 22. Name and Address of Fecility Baltimore, Maryland 21202 21. Signature of Funeral Service Licensee seman WM.C.March FH 1101 E. North Avenue ompon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete tnterval Between Onset and Death immediate Cause (Final disease or condition resulting in deeth) . EMD STAGE REMAL OSEASE 6 months Due to (or as a consequence of) MIABETES MELLITUS Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Onknown AKTERY POLJEAJE COROMARY 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Was en eutopsy performed? DEMEMILA 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Ptece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28c. fnjury et Work? 5 Pending investigation 1 Maturel 1 Yes 2 No 2 Accident

à ST.

Physician

· /Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

7 is merked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

e filed within 72 hours after all Hygiana.

permit. Pagas 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event.

Physician

/Medical

Examiner

Examiner

Physician/Medical

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Completed

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2

Certification:

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3 Sulcide

29a. Certifie

4 Homicide

(Check only one)

29b. Signeture end title of certifier

31. Dete filed (Month, Dey, Yeer)

altimore,

with the Maryland

death

after deat Director: 8 24 hours Funaral

To the I within 2 To the I

State Registrar

30. Neme and eddress of person who completed ceuse of death (Item 23a) (Type, Print) ALEEM HARID

6 Could not be determined

OCT 1 3 2000

9101 FRANKLIN 32. Registrar's Signeture

MY

SOVAREDRIVE BACTIMINE MD 21237

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

47945

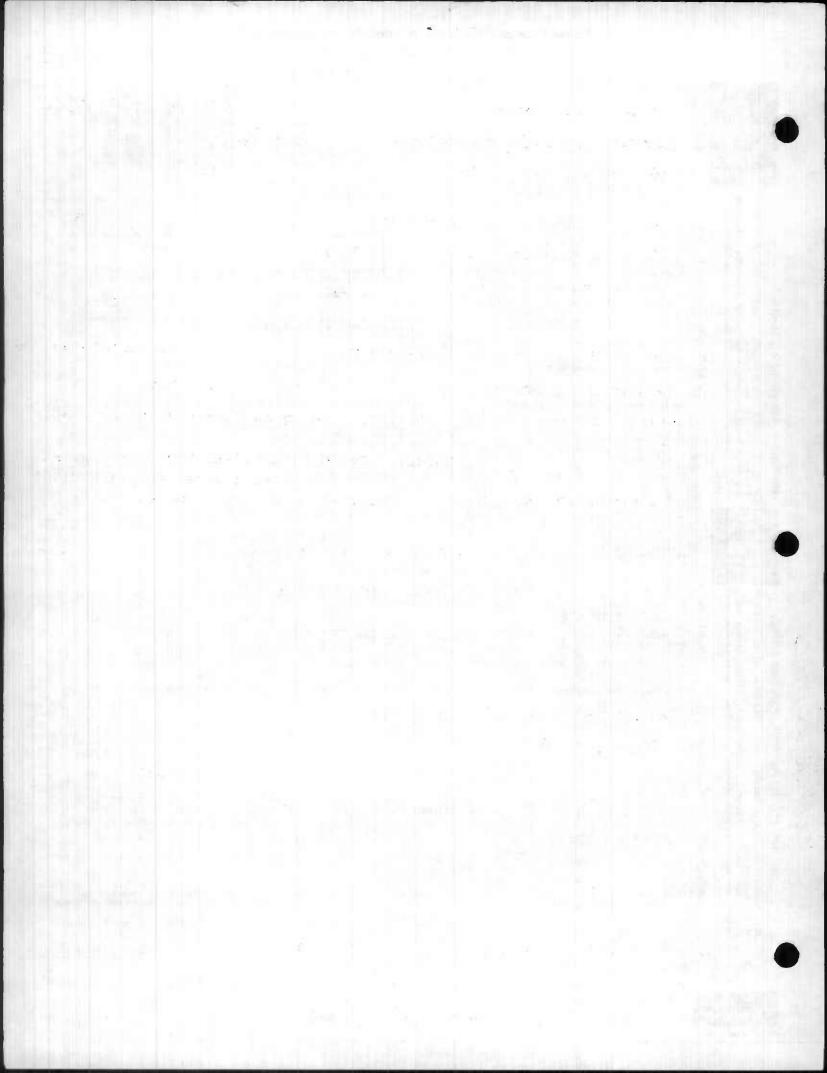
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

PO 720

29d. Date signed (Month, Day, Year)

2000

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death **Physician** Howard Schooler Brewer 3:00 P.M. October 1 11, 2000 /Medical 4e Fecility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore Co. 8. Dete of Birth (Month, Dey, Year) August 15,1925 5. Social Sacurity Number If Undar 1 Yaar Birthplace (Stata or Foraign Country) 7. Aga (In vrs. last birthday) **Funeral** Months Deys Hours Min 1**X** M 2□ F 213-20-4009 75 Baltimore, Maryland Director Usual Rasidence of Decedant 10c. City, Town or Location 10d. Inside City Limits 10a. Stata 10b. County 1 Yes 2 No Mary land Baltimore Co. Director **Baltimore** 288-7 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 8 19 A Mopec Circle Merrie 23a 21236 United States of America 12. Was Decedant Evar in U,S. Armed Forces? 1 M Yas 2 □ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American Indian, Black, Whita, atc. 11. Marital Status 1 Nevar Married 2 Married 1 Yas 2 XNo Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elamentary/Secondary (0-12) College (1-4or 5+) Buyer **Antiques** 10 n/a 18. Mothar's Nama (First, Middle, Maidan Surname) 17. Fether's Name (First, Middle, Last) es 1 and 2 should be fi of Health and Mantal H I flam 27 is marked off George Ward Brewer Virgie Victoria Schooler 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Melinda Laupert(Sister) 912 Osyter Cove Drive Graysonville, Maryland 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) b Moreland Memorial Park 10/14/2000 Baltimore, Maryland 22. Name and Address of Fecility Ruck Towson Funeral Home, inc. 21. Signatura of Funeral Service Licensee Jeffrey L Gair 1050 York Rd. Towson, Md. 21204 Enter the success of complications that causad the death. Do not antar tha mode of dying, such as cardiac or raspiretory errast, or heart failure. List only one causa on each lina. Approximete Intarval Batween Onsat and Death **Physician** /Medical Immediata Cause (Finel disaasa or condition rasulting in death) Recurrent Meningioma Examiner Due to (or as a consequence of) Physician/Medical Examiner burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of) and physician s the burial 68760 Due to (or es e consequenca of) Box (23b. Did tobacco use contribute to the cause of death? Part It. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. the 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown ρ 24b. Wara autopsy findings eveilable prior to completion of cause of death? Completed 24a. Was an eutopsy performed? has 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No certificata Division of Vital Be 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 8 Dother (Specify) Hospice 10 1 ☐ Yes 2 No this 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred Certification: After t or Attending 1 Naturel
2 Accident 5 Pending 1 ☐ Yas 2 ☐ No after deeth. invastigation Director: 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 ☐ HomicIda To the Hospital o within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. 29a. Certifier Medicai (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatule end titla of artifier 1)43725 10/13/00 30. Nama and addrass of person who completed causa of daeth (Itam 23a) (Type, Print) 2300 Dulaney Valley Road, Timonium, MD Dr. Tariq Mahmood,

DHMH 16 Rev 6/95

2000

October 11,

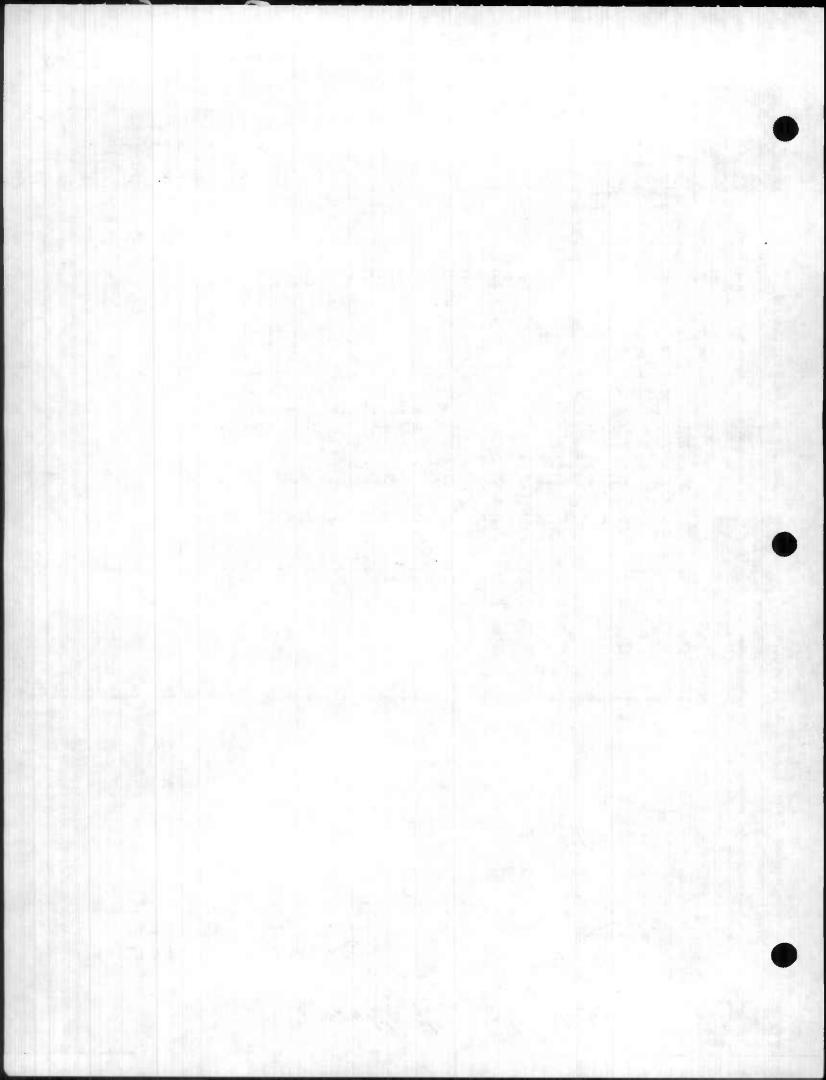
Howard Brewer

Registrar

31. Date filed (Month, Day, Year)

OCT 1 3 2000

32 Registrar's Signature 2 men



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te of Maryland	/ Department of Health and I	Mental Hygiene ()	32344
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or 28a-f	Dire	10e. Street and N					10f. Zip C	ode				10g. Citizen o	f What Cour	ntry?
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or Hem	Funer	11. Marital Status 1 ☐ Nevar Ma	rried 2 Married	Armad Fo	2 No CITE		/as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puarto ☐ Yes 2☑ No Specify:			Puarto	Rican, atc.)		ack, White,	etc.
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the M	Compl	Elementery/Secunk		College (1-4or 5+)	/// (1/10)	JO IVOT USB	1 STILE	<i>u</i>)					
ad other	Be	17. Fathar's Name	a (First, Middla, Last)		unk				18. Mothar's Neme (First, Middle,		e, Meiden Surn	, Meiden Surneme) unk		
and Me	raumatic To	19a. Informent's	Neme/Relationship (ype, Print) 19b. Meiling Address (Street e					t end Numbe	r or Rure	el Route Num	ber, City or Tow	m, Stete, Zip	Code)
auth a		0.04.5						tre	eet B	alti	more,	MD 212	01	
nant of Ha nt: If Ham	Ham Ham othe	20a. Method of Di 1 Burial : 4 Donation	isposition 2 □ Cremation 3 □ 5 △ Othar (Specify	Removel from	State	lece of Dispo ematery, crer	sition (Neme	of			Date	20c. Location		own, State
Department imports any inju	8000	21. Signature of	Fundral Service Licen	Wade, Director State Anatomy Board 655 W. Baltimore Stree Baltimore, MD 21201								Street		
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/Medic Examin		Immediate Cause disease or condit resulting in deeth	ion	e. DIABE		KETOACIDOSIS							1	
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Ician Durial	<u></u>	Sequentially list of any, leading to cause. Enter Unc	derlying or injury	c										
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pluodi	Completed b											is an autopsy formed?	81	fere autopsy findings vaileble prior to empletion of cause
has 9 29 2	ldm						3.50			1		√ .□	of	deeth?
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五百		27. Manner of De	ath 5 Pending	28a. Date (Mon		28b. Time of Injury	280	c. Inju Wo	ry at			e how injury occ		" OCLAVE
Attending or death. ector: After by the fune	Certification:	2 Accident 3 Suicide	6 Could not be	28e. Place	of Injury - At ho	ome, farm, str	eet, factory,]Yes 2□l				m <i>ber</i> or <i>R</i> ur	al Routa Number,
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within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)	1 Certifying Ph	iner: On the b										
within To the comple	N N	29b. Signatura aç	nd title of cartifiar				29c. I	Licens	sa number			29d. Data sig	ned (Month,	Dey, Year)
5 200								-	M.E			SEPTEMI		

L Chritim

O.C.M.E

SEPTEMBER 25,2000

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

Chutemo

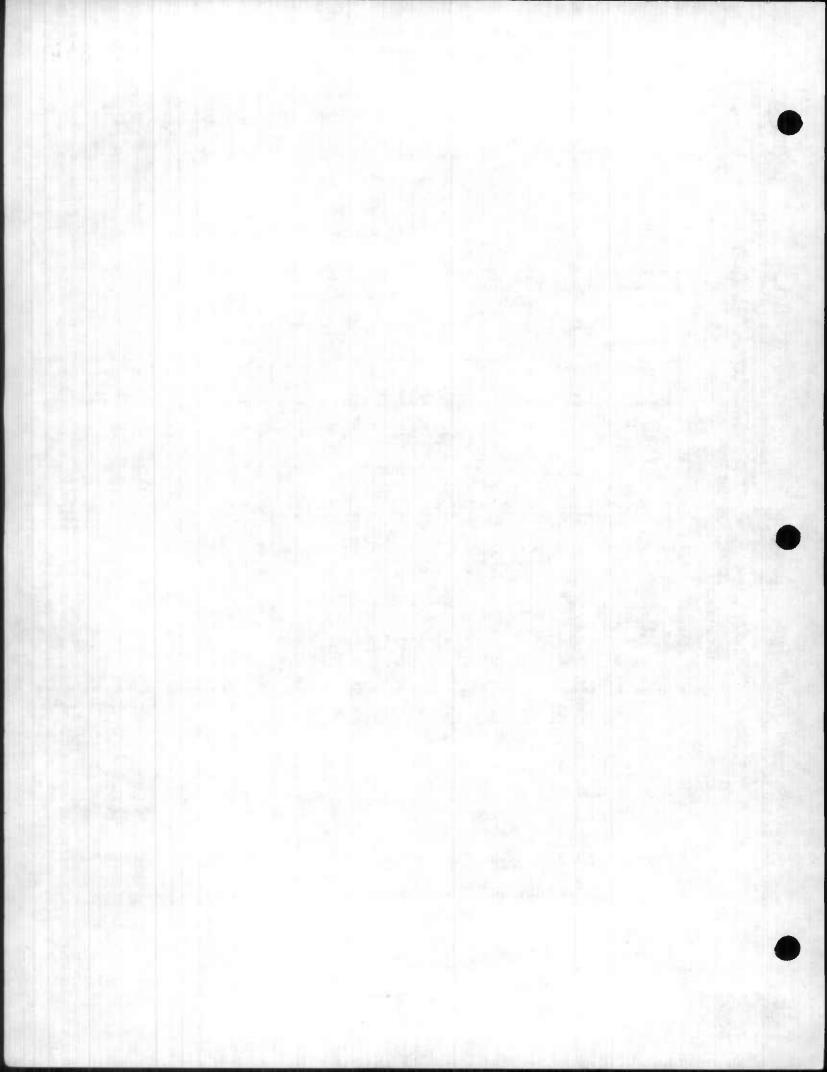
111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year) OCT 13

32. Registrer's Signature

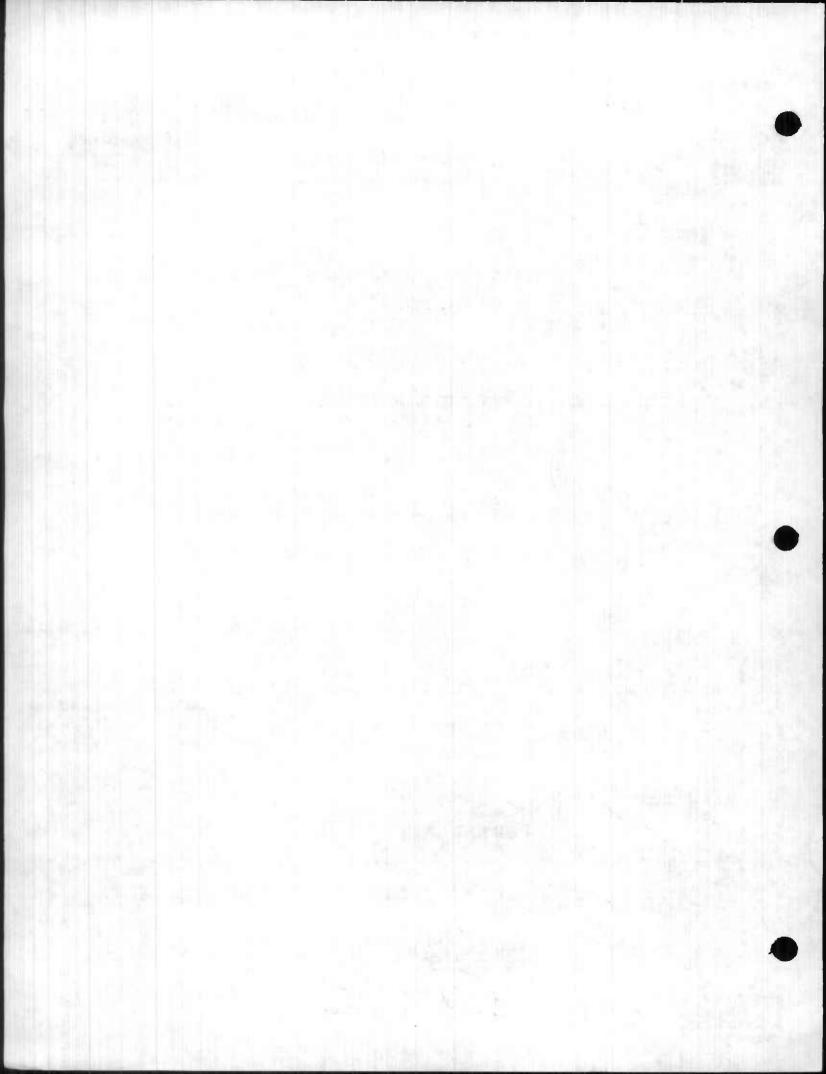
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State of Maryland / Department of Health and Mental Hygiene 00 32345

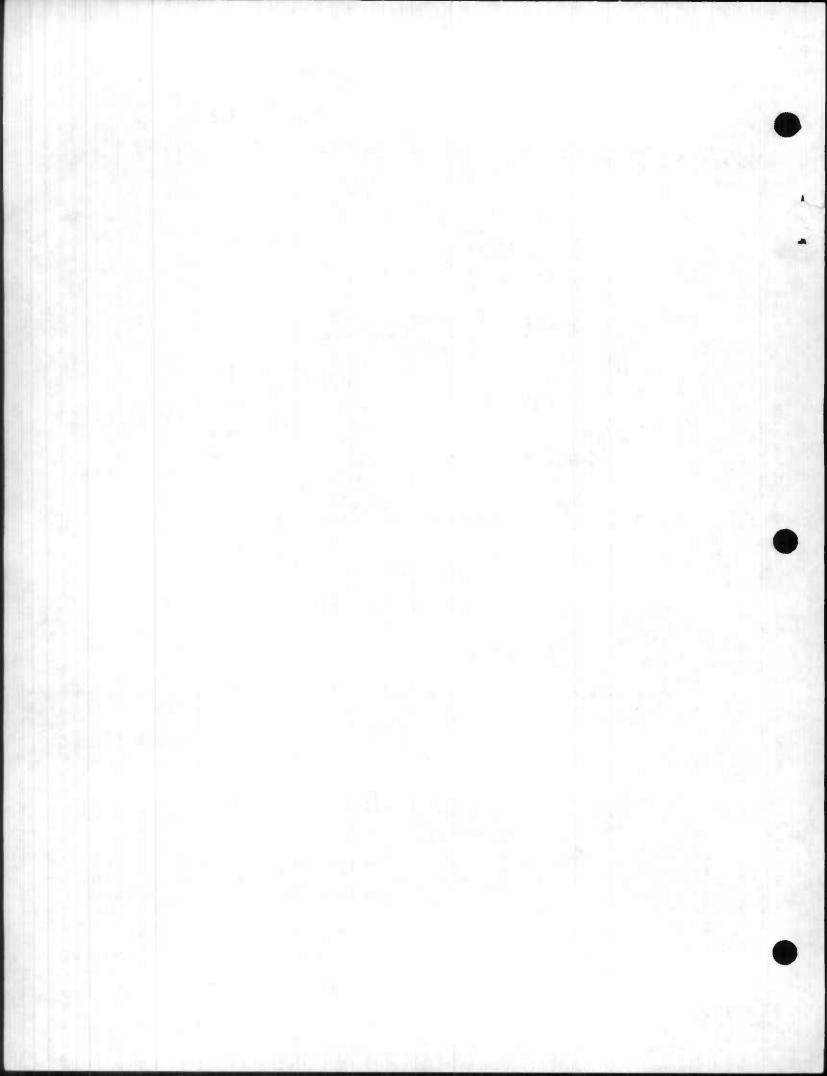
	Certificate of Death	h se	eg. No.	
	Decedent's Name (First, Middle, Last)	2. Date of Deat Month	h 3. Time of Death	
nysician Medical	MACK K. DOWMAN SR.	October		1.
niner	4a Facility Name (If not institution, give street and number) 4b. City,	Town, or Location of Death	4c. County of Death	
		n Burnie	Anne Arundel	
	245 32 6213 130 M 2 F 74 Yrs. Months Days Hours	ler 24 Hrs. 8. Date of Birth (Month, Day, April 3)		
	Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limit	
Directo	Maryland Anne Arundel Baltimore		0g. Citizen of What Country?	
	10e. Street and Number 108 - 3rd Avenue 101. Zip Coda 21225		U.S.	
by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever In U,S. Armed Forces? 12. Was Decedent Ever In U,S. If Yes, specify Cuban, Mexic If Yes, Sive Year or Dates: W.W. II		14. Race - American Indian, Black, Whita, etc. Specify: White	
pet	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during m	post of working	16b. Kind of Business/Industry	
Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 12th (Give kind of work done during m life. DO NOT use ratired) Yardmaster		Railroad	
Bec	17. Father's Name (First, Middle, Last) 18. Mol	ther's Name (First, Middle, Mi	Maiden Sumame)	
To B	William Jason Bowman	Pansie Ber	nfield	
	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Num	mber or Rural Route Number	, City or Town, State, Zip Code)	
	Mary Bowman / Wife 108 - 3rd Avenue	Baltimore	, Maryland 21225	
	20a. Method of Disposition 1		20c. Location - City or Town, State Glen Burnie, Marylan	nd
OUCS		Gonce Fi Highway Balt:	uneral Home P.A. imore, Md. 21225	
ledicai Examiner	23a. Part. Enter the delease complications that ceused the death. Do not enter the mode of dying, such a chock, or hear failure. It only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to or as a consequence of):		Unset and Death	
Physician/M	d Part II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Pa		obacco use contributs to the cause of deat	
by Ph		1 (3-)	2 No 3 Probably 4 Unkno	own
Completed		24a. Was a perfor	nn autopsy med? 24b. Were autopsy findings available prior to complation of causa of death?	3
Con		1 D Y	es 2040 10 Yes 2040	
Be (evaminer?	iace of Death (Check only or	na)	
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	4 Homicide determined determined building, atc. (Specify)	City or Tow		
edicai	29a. Certifier (Check only one) 1	death occurred at the time, d	late and place, and dua to the cause(s)	
×	29b. Signature and will by certify the signature of the s	94	29d. Date signad (Month, Day, Year)	
State	30. Name and address of person who completed cause of death/litem 23a) (Type, Print) Ello H	ood Rd, 6	sten Burne, unf, 21	06,



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

partment of Health and Mental Hygiene	00	2221
ertificate of Death Reg. No		32341

Ryan Colby amend item 2	23a,27, per me G788 10/17	State of Marylan 7/00 yf	d / Department Certificate			giene	00 3	12346				
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Examine			1	4b. City, Town, or								
5	5. Social Security Number 6. Se	Agnes Hospita	700 1 2 1	Balti Year If Under 24 Hrs			N/A 9. Birthplece	(State or Foreign				
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ahov	10a. Stete 10b. County	log. Cit	y, Town or Location Balton or					Inside City Limits 1 Ses 2 No				
vith the Ma	10e. Street and Number	No.	101. Zip C			10g. Citizen of V						
5-0020 72 hours after death with the Manyland natural; or thems 33a or 28a-f show are Examiner must be notified at	1801 N. DUKEL	AND STrEET		21216		USA						
Office death virther death virtherna 23s	11. Merifel Stefus	12. Wes Decedent Ever in U. Armed Forces?	S. 13. Was Decede	nt of Hispenic Origin? (S y Cuben, Mexican, Puer	Specify Yes or No-	14. Rac	e - American I	ndien,				
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1 21215-0 ed within 72 ho ygiene. er the Medical	Elementery/Secondery (0-12) 444 Grade	College (1-4or 5+)	StuDent									
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or Hear of Hea	KOBERT COBY / FR. 20a. Method of Disposition	O'4	Charles									
	1 Suriel 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specify	ure Ma	rylous									
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	23a. Pert . Enter the diseese, or comp shock, or heert failure. List only of	olications thet caused the deet one cause on each line.	h. Do not enter the mode	of dying, such es cardia	c or respiretory e	rest,	Int	proximete erval Between aset end Death				
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Vision Attending r deeth. ector: After	1 Neturel 5 Pending investigation		М	1 Yes 2 No								
Division of Vital Records, but or Attending Physician: The law requires the street deeth. In Director: After this certificate has been signed in by the funeral director, page 2 should be completed by	3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Specif	ome, ferm, street, fectory,	office	28f. Location (City or To	Street end Numb vn, Stete)	ber or Rurel R	oute Number,				
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Division To the Hospital or Attending I within 24 hours after deeth. To the Funeral Director: After completely filled in by the funeral Director.	29b. Signeture and fittle of certifier		29c.	License number		29d. Dafe signe	d (Month, Da	y. Year)				
	1 Atinh	1 1/1	15 n. n	O.C.M.E.		Oct	ober 10	0, 2000				
	30. Neme end address of person who d	completed cause of death (Item	23e) (Type, Print)			300	الله على حال	., 2000				
	Stephen S. R	adentz.	111 Penn St	reet, Balti	more, Ma	ryland	21201					
State	31. Dete filed (MOPP Pay 1Year) 201	32. Registrer's Signe	eture /									



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day ARTHUR CHAMBERS SEP 2000 D: 25 a.M. 30 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death 6. Sax 900 Catar Ave Baltimore If Undar 24 Hrs. 8. Day we 8. Date of Birth (Month, Dey, Yeer) Aug 13, 1932 Birthplaca (Stata or Foreign Country) unk 5. Social Security Number 7. Age (In yrs. lest birthday) Months Days Hours Min 1 M 2 □ F 68 Yrs. 142-24-5891 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 701 Edmondson Avenue 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian, Black, White, etc. 11 Marital Status 1 Yas 2 No If Yes, Give Yaar or Datas: 1 Nevar Married 2 Married 1 Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
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life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) St. Agnes Hospital 900 S. Caton Avenue Baltimore, MD 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) in State 21. Signature of Funeral Street Street Wade / Director State Anatomy Board 655 W. Baltimore Street Idele mun Baltimore, Md 21201 23a. Part Enter the disease, or complications that causad the death. Do not entar tha moda of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) month prevmonia Due to (or as a consequence of) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequenca of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an eutopsy performed? 1 Yas 25 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) axaminer? Hospital: 1 Lopatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injun

Examiner the 98 of Vital Records. P.O. page Division or Attending

Thambes

Examine Physician/Medical Aq Completed Be edical Certification: To

Physician

/Medical

Examiner

Director

Funeral

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Completed

MD

Funeral

Director

must be n

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al Hygiene.

permit. Pages 1 and 2 should be Department of Health and Mental Important: If them 27 is marked o any injury or other traumatic ave

important: If Ih any injury or o ance.

Physician

/Medical

Saltimore, Maryland 21215-0020

27. Manner of Death 1 Neturel 2 Accident 3 Suicide 4 Homicide

29b. Signature and title of certifier

29a. Certifier

5 Pending investigation

6 Could not be determined

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner steted. 29d. Date signed (Month, Day, Year) 29c. License number

impleted cause of death (Item 23a) (Type, Print) 30. Name and address of person will

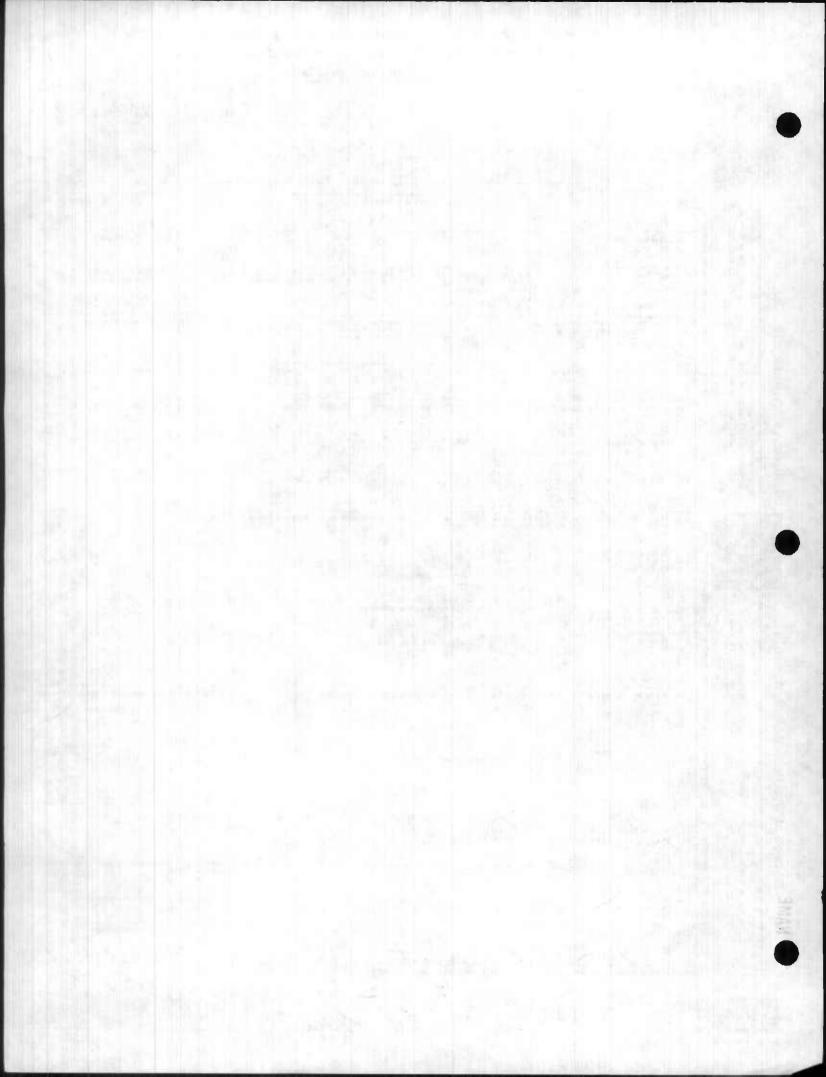
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Wichal. 31. Date filed (Month, Dey,

sie Registrar's Signeture 2000

Registrar

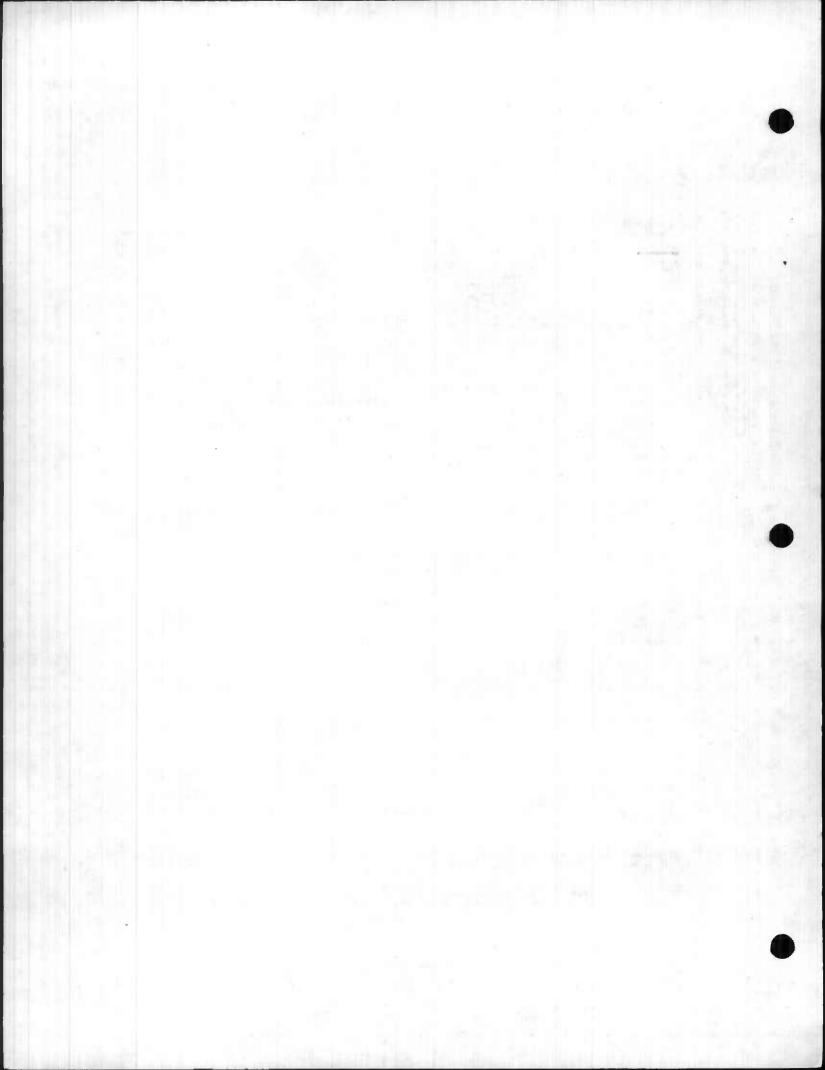
To the Hospital
within 24 hours a
To the Funeral Completely filled Hospital



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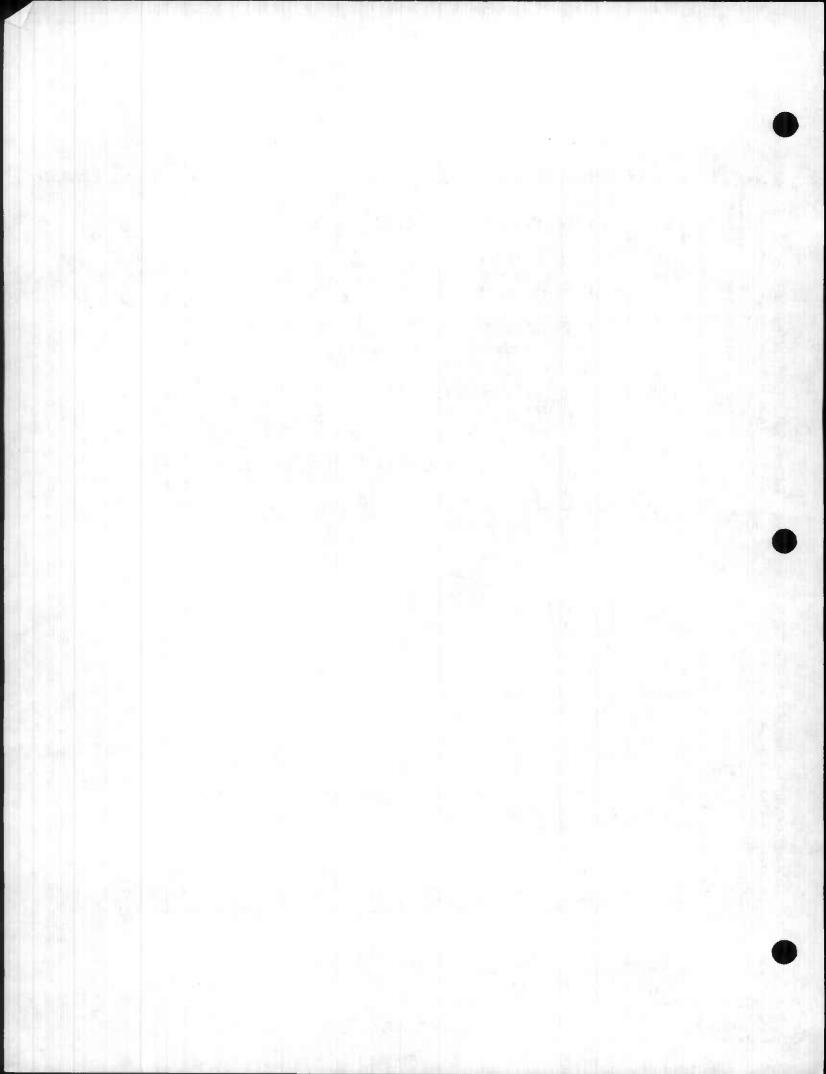
State of Maryland / Department of Health and Mental Hygiene Amend Item 10e per FH,788,10/13/00 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CANNADY, Jr. Year **Physician** 0 9:40 CH 10 m BUS 2000 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA JOSEPH RITCHIE HOSPICE BALFIAUVE If Under 24 Hrs. 8 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1ÈM 2□F 59 14-38-1393 Director mary Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BATHMOR NIA 1 Nos 2 No Director Mary Jano 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6 U512 2/2/7 SWEET 10C/c White Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes Z⊠No If Yes, Give Year or Dates: 1 Nevar Married 22 Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 BNo Specify. Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Whiting luener Elementary/Secondary (0-12) College (1-4or 5+) prooner 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LOYVAINE 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / / / Bil ROAD torest Owins Mills ILLIAN mmson 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition / Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal trom State CEMETER 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the officeation, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final The liner disease or condition resulting in deeth) errhores xamin i Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yee 2 X No 3 Probably 4 Unknown by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 1 ☐ Yes 2 ☑ No Division of Vital 25. Wes case reterred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Pother (Specify) However 1 Yes 2 No Medicai Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 De Netural 1 Yes 2 No death. 2 Accident Olrector: 6 ☐ Could not be determined 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 5 n 24 hours a 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Benny. 8583 10/11/2000 12000 30, Nama and address of person who completed cause of death (Item 23a) (Type, Print) Tchie Denedic 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 13 Deneva 200D Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

Wayne T. Cr amend ite	State of Maryland / Department of Health and Moreover me G788 10/23/00 yf Certificate of Death	ntal Hygier Reg. 1	,00	12349
Dhunia	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Tima of Death
Physici /Medi	at WUYNE I CRONNER		ð, 2000 í	1:28 P.M.
Examir	49 Facility Name (If not institution, give street enti number) 45. City, Town, or L		4c. County of Death	
AVB _	Good Samaritan Hospital Baltim 5 Social Security Number 6 Sex 7 Ang (In yrs. last birthday) Under 1 Year If Under 24 Hrs.		N/A	
Funeral Director	5. Social Security Number 6. Sex 1 X M 2 F 7. Age (In yrs. last birthday) Wonths Days Hours Min. 1 Sual Residence of Decedent	8. Dale of Birth Month, Day Yea	1944 M	place (State or Forming)
Mand	10a. Slate 10b. County 10c. City, Town or Location			10d. Inside City Limits
5-0020 72 hours after death with the Manyland neturel', or theme 23e or 28e-f show	# Md Baltimore Parkville			1 ☐ Yes 2 No
th the	10e. Streel and Number 10f. Zip Coda 10f. Zip Coda 10f. Zip Coda 10f. Zip Coda 11 Marital Slatus 12 Was Decedent Levr in U.S. Armed Rorces? 1 Never Merried 10f. Zip Coda 11 Nas Decedent of Hispanic Origin? (Sp. If Yes, specify Cuben, Mexican, Puerto	10g.	Citizen of What Cou	intry?
23 w	= X722/2 Old Nariord Rd. 21234		USA	
	11. Marital Slatus 12. Was Decedent Ever in U,S. Armed Refces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuben, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri Bleck, White	
20 safe	1 Never Merried 2 Merried 1 Yes 2 No Hys, Give 1 Yes 2 No Specity: Yes or Dates:		Specify:	hide
11215-0020 within 72 hours after ena. then "netural; or ite		16b	. Kind of Business/Ir	ndustry
215 27 nin 72	(Specify only highest grade completed) (Give kind of work done during most of work	king	11/2 6	long
212 d with	Elementary/Secondery (0-12) College (1-4or 5+) Managel	M	igns w	ere
Aaryland 2 2 should be filed and Mental Hygid is marked other surretic event, is	17. Fether's Name (First, Middle, Last)	e (First, Middle, Maid	den Surname)	Λ
arylan should be nd Mental i merked o		USI L	indal	
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours af operational of health and Mental hygiena. Important: If them 27 is marked other than "natural", or may injury or other traumatic event, in Nex at Emphase.	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	ral Route Number, Cit	hypr Town, State, Zi	p Code) 21284
ore, No. 1 and 3 a	20e. Method of Disposition 20b. Place of Disposition (Name of	XXXXX I	JULYHMO,	e, Ma
Pages 1 nant of H	20b. Method of Disposition 20b. Placa of Disposition (Name of cemetery crematory or other place)	3ct. 14 20c.	Location - City or T	own, State
Baltimo Department of Important of Imp Injury or	4 Donation 5 Dother (Specify)	2000 PC	REVILLE	Ma
Baltii pemit. F Departmany Importan any Injure	21. Signature of Emeral Service Licensea	ians fun	iral che	apel
	Mells 8800 Harjord	Rd. Balt	emore, M	d 21234
	255. Pant 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart lailure. List only one cause on each line.	or respiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISFASE Due to (or as a consequence of):			
D .5	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying			
y and al-trar	Sequentially list conditions, if eny, leading to immediate		1	
8760, tate be axecuted hysiclen and the burial-transit	Cause (Disease or injury C.			
68 flicate phy as the	That initiated events Due to (or as a consequence of):			
death cartifica a attending place of for use as t	d			
• 0 6 2	d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobac	co use contribute	to the cause of death?
D.O. at the by the stacket	A CONTRACTOR OF THE CONTRACTOR	1 Yes	2□ No 3□ Pr	obably 4 Unknows
ecords, P.O. law requires that the las been signed by the a 2 should be datache	٥			
cord v require been si	Completed	24a. Was an ai	1? a	Vere autopsy lindings vailable prior to completion of ceuse
Aec a law r has by	and and and and and and and and and and			I death?
Tha It	O C C C C C C C C C C C C C C C C C C C	Yes	2□ No 1	Yes 2□ No
f Vital I ysiclen: Thu	25. Was case referred to medical examiner?	th (Check only one)		
of Vita Physicien: rthis cartific	1 Inpalient 2 ER/Outpatient 3 DOA 4 Nursing H	ome 5 Residence		sify)
On of	27. Mannar of Deeth 28a. Date of Injury 1 ☑Natural 5 ☐ Pending (Month, Day Year) 1 ☑Natural 5 ☐ pending investigation 1 ☑Natural 5 ☐ Pending (Month, Day Year) 1 ☐ Yes 2 ☐ No	200. DESCRIBE NOW II	njury occurred	
Division of Attending after death of Divector: Attending	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined determined	28f. Location (Street	t and Number or Ru	ral Route Number.
Or A star	4 Homicide determined building, atc. (Specify)	City or Town, S	tata)	
Division or To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral	27. Mannar of Deeth Natural	, and due to the caus	a(s) and manner as	stated.
To the Hospital within 24 hours To the Funeral completaly filled	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and mannar stated.	rred et tha lime, date	and placa, end due	to the cause(s)
To th Withir To th	29b. Signifier and title of partitier 29c. License number	29d.	Date signed (Month	, Day, Year)
	Valorkenn O.C.M.E.	Oc	tober 11,	2000
	30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print)			
	J. CARCN Cocker, MD 111 Penn Street, Balt	imore, Mar	yland 212	201
Sta	te 31. Dete liled (Month, Day, Year) 32 Registrer's Signature			
Registr	ar OCT 13 2000 Some B. Sports			



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

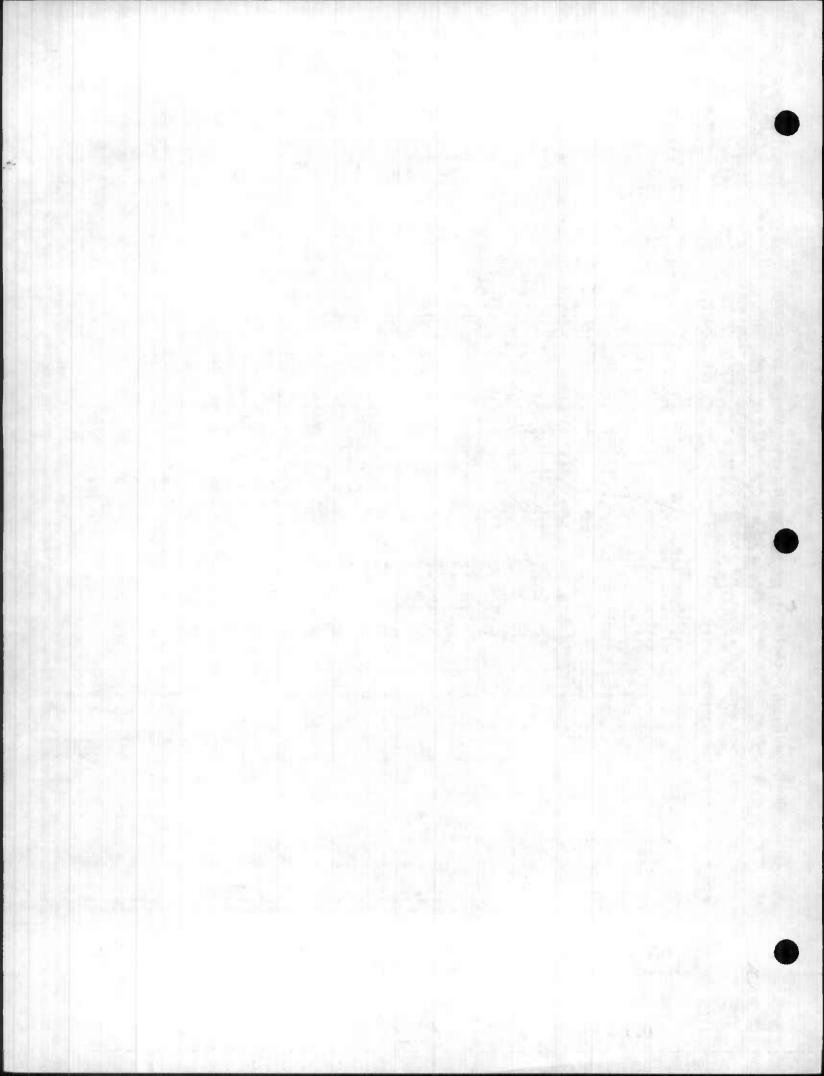
em#30 perDVRG788 10/13			Certificate	or Death		eg. No.	0 32350
Decedent's Name (First, Middle, L.	1 1				2. Date of Deal Month	Dey	3. Time of Death
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4e Fecility Name (If not institution, gi	ive street and number)			4b. City, Town, or Lo	cation of Death	4c. County	of Death
IVY HALL	VURSING	Han	<i>(</i> -	Middle K	DIVER	RO	LTIMORG
	Sex 7. Age	(In yrs. last birt	hdey) If Under 1 Y	eer If Under 24 Hrs.	8. Dete of Birth		Birthplace (State or Foreign Country)
212 05 9797	125M 2□ F		Yrs. Months D	ys Hours Min.	(Month, Dey,	10 11	Country)
Usuai Residence of Decedent		07			YAN. 197	1710	ма.
10a. State 10b. County		10c. City, Towr	or Location			10 July 10	10d. Inside City Limits
1.1	38 33 37	2	200				1 ☐ Yes 2 € No
Ma BALT	IMORE	K	OSEDALE				
Md BALT			10f, Zip Co		- 1	0g. Citizen of W	/het Country?
1400 SPRING	AUE		21	237		45.	A
11. Maritel Status	12. Was Decedeni E Armed Forces?	ver in U,S.	13. Was Decedent	of Hispanic Origin? (Spo	ecity Yes or No-		- American Indian,
11. Maritel Status 1 Never Married 2 Married	1 Yes 2 No			Cuban, Mexicen, Puerto	rican, etc.)		k, White, etc.
3 Widowed 4 Divorced	If Yes, Give Yeer or Dates:		1□ Yes 2⊠	No Specify:		Specify:	WHITE
15. Decedent's E	ducation	16a.	Decedent's Usual O	cupation		16b. Kind of Bu	siness/Industry
(Specify only highest gi	rade completed)		(Give kind of work di	one during most of works	ing		
Elementery/Secondery (0-12)	College (1-4or 5+			PRKER		GMC	7
17. Father's Name (First, Middle, Las	-01	0.50	N33 VVC	18. Mother's Name	/Eiret Middle		
						_	9/
GEORGE W. MC	CLELLANI			MARGA	RET E	· FIN	X
19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address (St	reet and Number or Run	al Route Number	City or Town,	Stete, Zip Code)
MARY M. McCI	ELLAND	14	400 SDA	NOG AV.	BALTE	Md. 2	1237
20a. Method of Disposition		20b. Place of	Disposition (Neme of	1		20c. Location -	City or Town, Slale
1 Burial 2 Cremation 3			y, crematory or other	~	14/00		111
4 Donation 5 Other (Spec	-	GREE	M MOUNT	CREM-	700	BALTO	Md.
21. Signature of Funeral Service Lice	ensee _		HAETLE	Idress of Facility RF	UNERAL	HOME,	CH10-
1110-11/21/11	miller		7527	HARFORD	R1.13	1/2 N	1d. 21234
Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying	b. CHRONIC	oue to (or es e	consequence of):	IVE HE	GRT F	914486	5
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Pert II. Other significant conditions	ATHER	DSCLE		CARDONA	9SCULAR	DISE	956
Pert II. Other significant conditions	contributing to death but	not resulting in	the underlying ceus	given in Part f.	23b. Did to	bacco usa con	tribute to the cause of death?
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					perfor	med?	eveilable prior to completion of ceuse
							of death?
					1 Y	es 20 No	1 ☐ Yes 2 ☐ No
				26. Piece of Deatl	h (Check only on	Θ)	
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State Registrar

DHMH 16 Rav 6/95

OCT 1 3 2000

32. Registrar's Signature

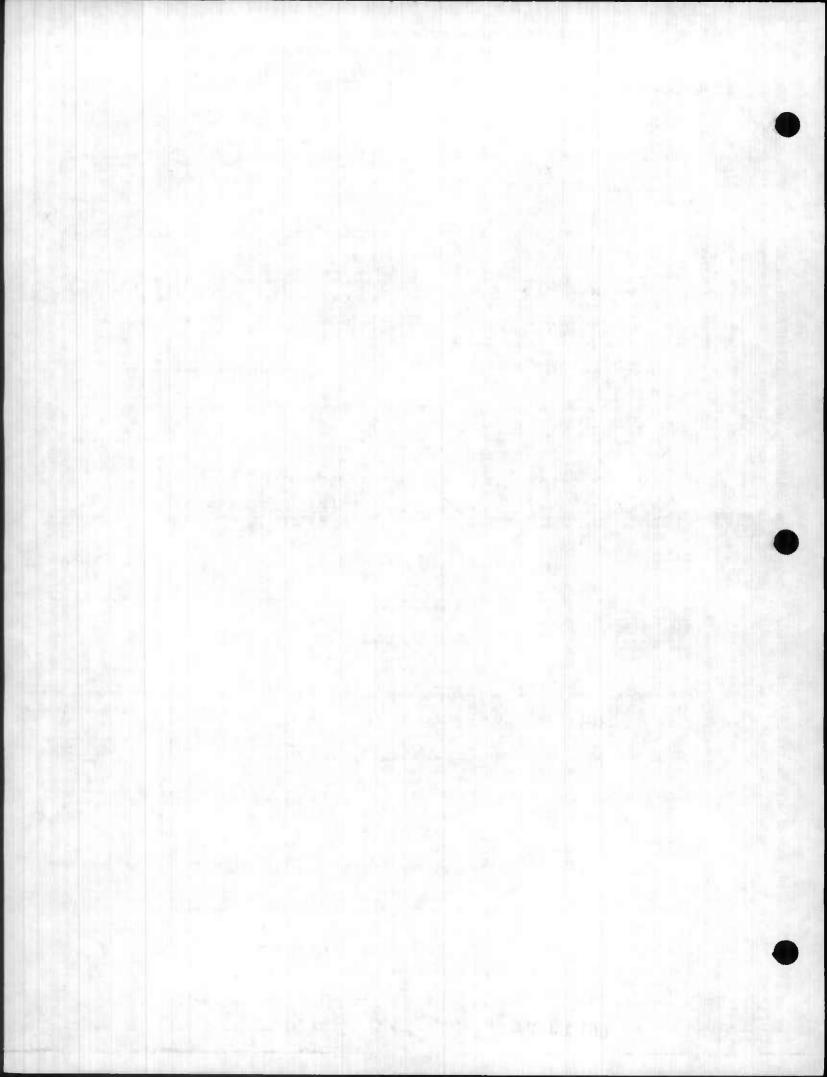


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State of Maryland / Department of Health and Mental Hygiene 00 32351

						Certific	cate of	Death		Re	g. No.		2001
	DI		Decedent's Name (First, Middle, Las	it)			Y-07-3			2. Date of Deat Month	h	ear	3. Time of Death
201	Physicia: /Medica		John	Α.		Ce	rro			october	(/ /) -		4:30 AM
	Examine	4.	Facility Name (If not institution, give							cation of Death	4c. County of		
			Mercy at Stell				Jadas 4 Vags	Balt			N/A		
	Funeral Director	2	Social Security Number 6. S 2.16-16-2375 sual Residence of Decedent	MM 2FF	(In yrs. last birt		Inder 1 Year onths Days	If Under : Hours	Min.	8. Date of Birth (Month, Day, Feb. 1	Year) 6,1925	Birthpl Count MC	ece (State or Foreign lry)
	pu ku		Oa. State 10b. County		10c. City, Town	or Location	n				5 II .	10	Od. tnside City Limits
	ath with the Marylar 23a or 28a-f show	Director	Md. Baltin	ore	Dunda		M. Zin Ondo				og. Citizen of Wha	1000	1 ☐ Yes 25(No
	ath with	ra Dir	0e. Street and Number 8029 Park Have				2122				USA		
020	urs of	by Fur	1. Marital Status 1. Never Married 2. Married 3. Widowed 4. Divorced	12. Was Decedent Ev Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:			Decedent of F , specify Cub es 2 No	an, Mexican Specify:	gin? (Spi , Puerto	ecify Yes or No- Rican, etc.)	14. Raca - Black, Specify:	White, e	
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Baltimore,	S T T S	2	Da. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specify		20b. Place of cerneter. Holly	y, cremator	y or other pla	сө)	C	oct 10	iddle F		
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	/Medical Examiner	0	mmediate Cause (Final disease or condition esulting in deeth)	. Lung	Jue to (or as a c	Mul	2/) :a of):					-	gears
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Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined		ry - At home, fa (Specify)					28f. Location (Si City or Town	reet and Number n, State)	or Rura	I Route Number,
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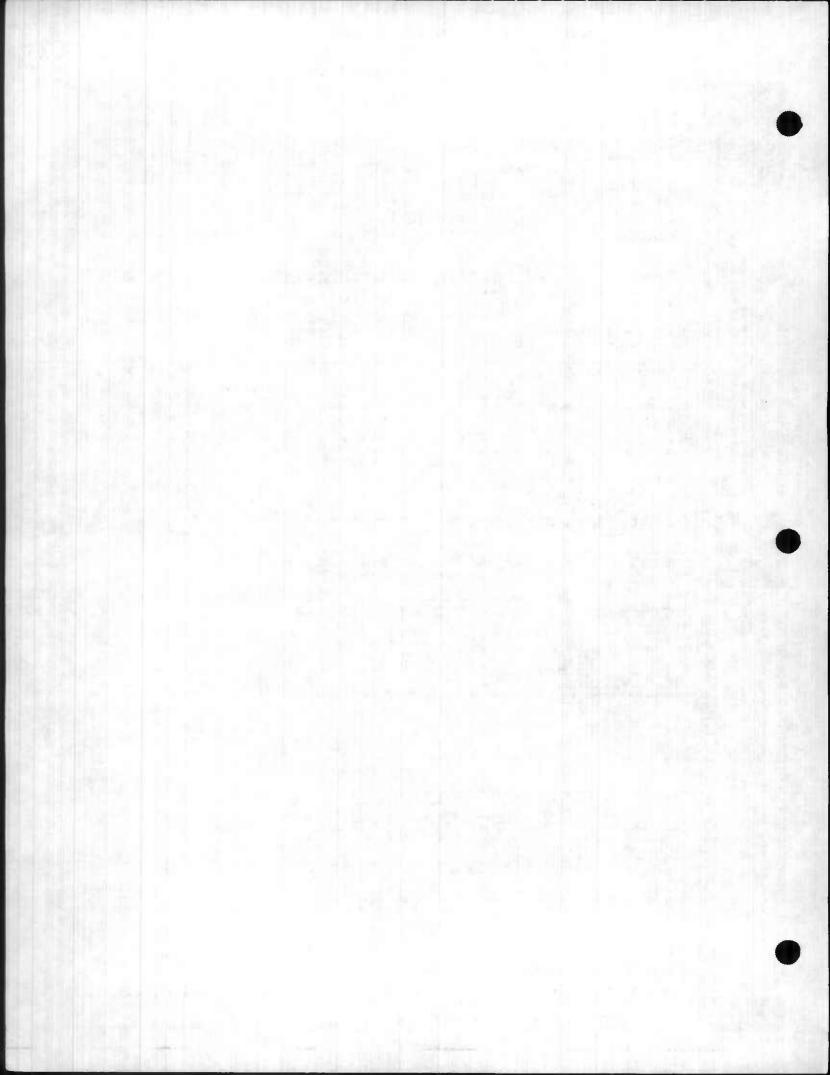
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Decedent's Nam	ne (First, Middle	e (ast)									2. Date of C	loath			3. Time of Death
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amended Item#30 perDVRG788 10/13/200 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#17 perFHG788 10/13/2000 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10, **Physician** Rosa Mae Duncan October 2000 10:45pm /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Nursing Home Baltimore Rosedale If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Deys Hours 1 □ M 2 X F Yrs 91 Director 240-03-2946 May 2,1909 North Carolina Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Baltimore Middle River 28s-f: Director 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 8 the Medical Examiner must be Norna 23a 108 Compass Road 21220 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 孝 ★ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Merried b Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White py 3℃Vidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Mental should be Thomas Ladender Lavender Donnie Dale 19a. intormant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) ä Mem 27 Eileen Lorenton/Daughter r 108 Compass Road, 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, MD 2122
Date 20c. Location - City or Town, State 21220 Baltimore, 20a. Method of Disposition Pages Department of Important: If It any injury or o 8 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/14/00 Baltimore, MD Holly Hill 22. Name and Address of Facility Connelly Funeral Home Of Essex 300 Mace Avenue, Baltimore, MD 21221 sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examine The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disease or Injury that initiated events resulting In death) Last Box 68760. Physician/Medicai Due to (or as a consequence of): P.O. Part II. Other eignificant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by i 1 Yes No 3 Probably 4 Unknown þ of Vital Records. this certificate hes been si ral director, page 2 should 24b. Were autopsy tindings available prior to completion of cause ot deeth? 24a. Was en autopsy Be Completed performed? 200 1 ☐ Yes 1 Yes 2 10 i or Attending Physician: after death. 25. Was case refarred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other (Specify) 1 Yes Medical Certification: To 28c. Injury at Work? 27. Manner-of Death 28b. Time of 28d. Describe how injury occurred Division Natural 5 Pending investigation after death.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accidant 28t. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be 3 Suicide 28e. Place of Injury - At homa, tarm, streat, tactory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital within 24 hours a To the Funeral Completaly filled 29a. Certified 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, data and place, and dua to the cause(s) and manner stated. 29b. Signatura and titla ot certitier 29d. Date signed (Morgh, Day, Year) 29c. License number

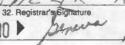
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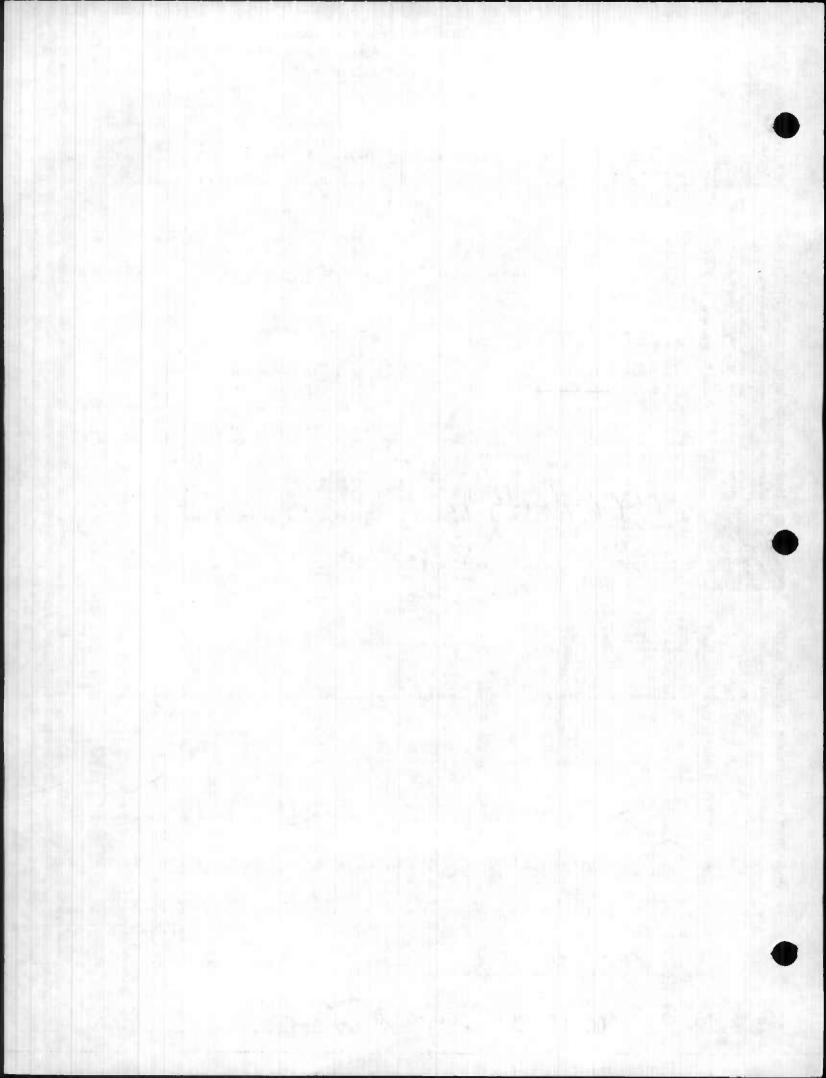
State Registrar 31. Date filed (Month, Day, Year) 32. R

30. Name and eddrass of person who completed cause of death (Item 23a) (Type, Print)

Rul



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Funeral Director deeth with the Marylend 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 2 should be filled within 72 hours after on the Mental Hygiena. Is marked other than "natural", or ita Saltimore, Maryland 21215-0020 permit. Pages 1 end 2 sh Department of Health end Important: if item 27 is m any injury or other traum once.

Physician

/Medical

Physician /Medical Examiner

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certificate be axecuted i or Attanding Pi efter death. the 2 Hospital To the Hospital within 24 hours of To the Funeral I completely filled

Box 68760.

P.O.

Records.

Division of Vital

Examiner WILLIAMSPORT NURSING HOME 5. Sociel Security Number 220-38-1788 Usual Residence of Decedent MT 10e. Street end Number 154 N. ARTIZAN ST. USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 Û No It Yes, Give Year or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Meritel Stetus 14. Rece - American indien, Black, White, etc. 1 Never Married 2 Marriad 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ₩idowed 4 Divorced WHITE Completed 15. Decedent's Educetion (Specify only highest grade completed) 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) LAWRENCE P. FROSTBUTTER SUSAN DAVIS P 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) ROBERT G. DREVENAK / SON 22005 DICKERSON RD., DICKERSON, MD 20842 20b. Place of Disposition (Name of cemetery, cremetory or other place)
PLEASANT VIEW MEMORY GARDENS 20a Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removal from State 10/13/00 MARTINSBURG. WV 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerei Service Licensee 22 Name and Address of Facility BROWN FUNERAL HOME, 327 W. KING ST., harles m PO BOX 821, MARTINSBURG, WV 25402 23e. Pert1. Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errast, shock, or heart tailure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediata Cause (Finel disease or condition resulting in death) Preumonia 48 hours Due to (or es a consequence ot) Examiner Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of): Physician/Medical thet initiated events resulting in deeth) Last Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Senile Dementia. þ 24b. Wara autopsy tindings 24a. Wes an autopsy Completed eveileble prior to completion of ceuse of death? performed' 2 No 1 Yes 2 No 1 Yes 25. Was case reterred to medical examiner? Be 28. Pleca of Daath (Check only one) Hospital: 1 inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2√ No L_o 27. Manner of Death 28e. Deta of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Couid not be datermined 28t. Location (Street end Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At home, ferm, street, tactory, office building, etc. (Specify) 4 Homleide 1 Certifying Physicien: To tha best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and mannar as stated.

2 Medicel Examiner: On the bests of examination and/or investigation, in my opinion, death occurred et the time, date and pleca, and due to tha causa(s) and menner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certities 29c. License number 29d. Date signed (Month, Dey, Year) Mour. D33700 OCTOTSETS 10, 2000 30. Name and address of parson who completed ceuse of deeth (Itam 23a) (Type, Print)

(SOONSTSORO MD

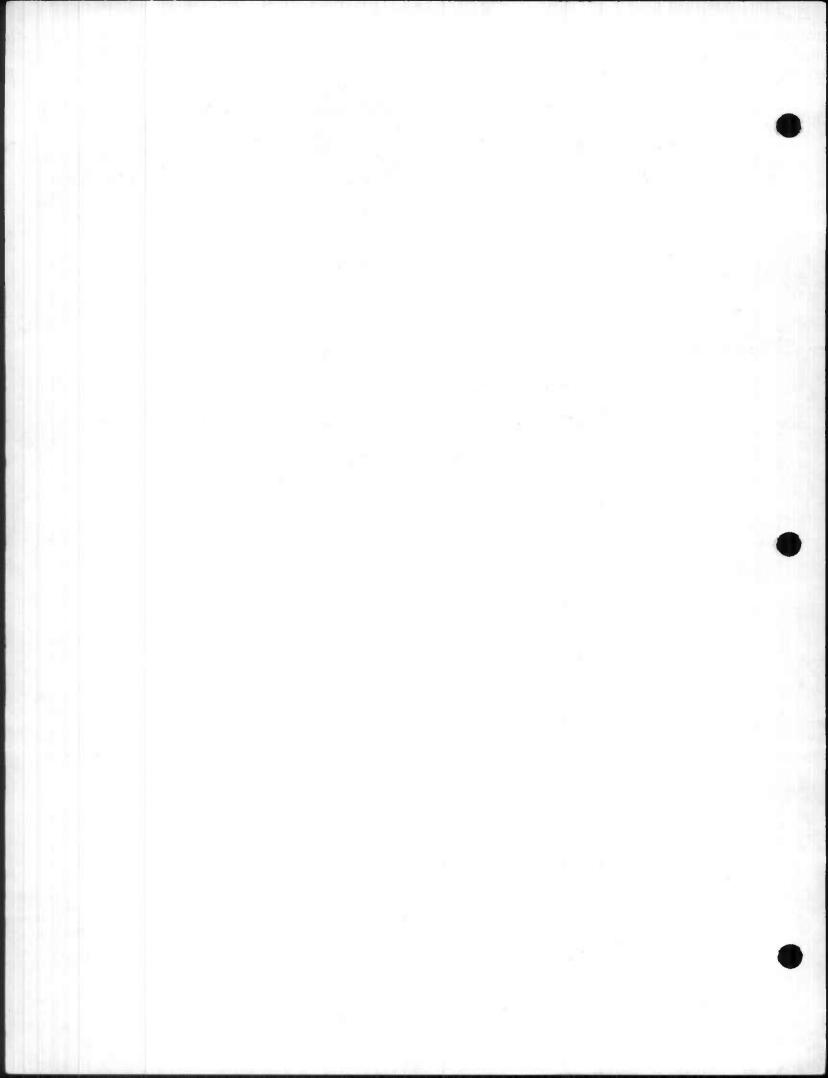
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State Registrar IED HOWE

31. Date filed (Month, Day, Year)

OVERWOLL

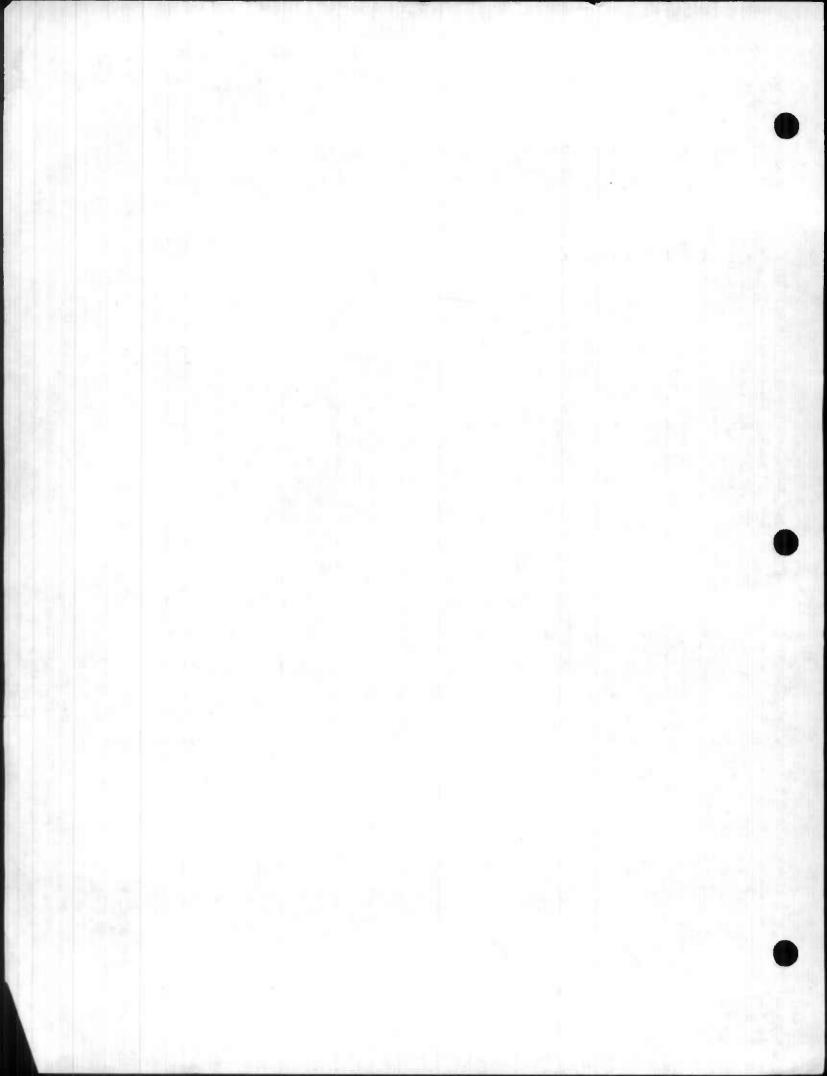
32. Registrer's Signeture



Please Type or Print in Biack Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 3 5 5

hysician	1. Decedent's Nama (First, Middla, L	.ast)				2. Data of Death	Day	3. Tima of De				
•	Stephen D.	Dearborn				Month OCTOBER	8, 20	00 1035				
/Medical Examiner	4a Facility Nama (If not institution, g	iva street and number)			4b. City, Town, or Loc	ation of Death	4c. County of					
	3513 SALUDA RO	DAD			PARVILLE		BALTI	MORE				
neral rector		Sex 7. Aga (In y	rs. last birthday) 6 Yrs.	If Under 1 Yaar Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, Y July 28,	^(ear) 1954	9. Birthplaca (Stata or Fo Country) Maryland				
	Usual Rasidence of Dacedant 10a. Stata 10b. County	100	City, Town or Lo	cation				10d. Insida City L				
miner must be notified at r Funeral Director								1 □ Yas 2				
Director	MD Baltimo	ore B	altimore	10f. Zip Coda		100	. Citizan of W					
0	3513 Saluda Road			21236			U.S.A					
Funeral	11. Marital Status	12. Was Decedant Evar in	U,S. 13. y		dispanic Origin? (Specan, Maxican, Puarto P	city Yas or No-	14. Race	- Amarican Indian,				
à	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yas 2 No if Yas, Giva Yaar or Datas:		Yas, specify Cub		ican, atc.)		White White				
a bete	15. Decedent's (Specify only highest g	Education grada completed)	16a. Deced	lent's Usual Occup	pation during most of workin d)	a 16	b. Kind of Bus	sinass/Industry				
Completed	Elementery/Secondery (0-12)	College (1-4or 5+)			d)		Automo	tive				
	12	A#1	Me	echanic	19 Mathada Nama							
80	17. Fathar's Nema (First, Middle, Les Floyd W. Dearbon				18. Mother's Nama Alice J.		our surname	-/				
5	19e. Informent's Name/Reletionship		10h Mailin	n Address (Ctrost	end Number or Rural		City of Town	State Zin Code)				
	Mrs. Jayne M. De			Saluda R		more, Ma						
	20a. Mathod of Disposition			sition (Nama of natory or other pla	bad barti			City or Town, Stata				
	1 Burial 2 Cramation 3 4 Donation 5 Other (Spec	LIHamoval from Stata		Service		0/12/00	Towson	, Maryland				
	21. Signatura of Funaral Sarvice Lic		00	. Nama and Addre	on of English							
any injury pass	Heather Cain Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214											
	23a. Part1. Entar tha disaasa, or co shock, or heart feilure. List on	molications that caused the de	O not ant	ar the mode of dvi	or a Road B	arraspiratory arras	, Mary	Approximata				
the buriel-trensit	resulting in death) Sequentially list conditions, if any leading to immediate	b	o (or as a conseq									
edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last	cDua to	o (or as a conseq	uenca of):								
0 0	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the conditions conditions contribute to the conditions cond											
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by Physician	Pert II. Other significant conditions	contributing to death but not	rasulting in tha u	ndarlying causa gi	van in Part I.	23b. Did tob		tributa to the causa of c				
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should be detached leted by Physi	25. Was casa ratarred to medical	contributing to death but not	rasulting in tha u	ndarlying causa gi	van in Part I.	1 Yes	autopsy ed?	3 Probably 4 Un 24b. Wara autopsy find available prior to completion of cau of deeth?				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #8 PER F.H. G788 10-24-00 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 0352 Dally 00 10 07 /Medical 4a Facility Name (I not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Hopkins Bayview Johns (In yrs. last birthday) If Under 1 Yaar 8. Date of Birth (Month, Day, Year) 02/12/12 Birthplace (State or Foreign Country) **Funeral** 10M 20F Months Days Hours Min 185-05-1931 PA Director Usual Residence of Decedent 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or hama 23a or than "natural", or items 23s or the Medical Examiner must be. 2825 Lodge Farm Road 21219 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 GHO If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 □ Never Married 2 □ Married Specify: Caucasian Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: à ₩idowed 4 Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) 1 Flementery/Secondary (0-12) College (1-4or 5+) Operator Security App. 18. Mother's Nama (First, Middle, Maiden Surnama) 17. Fathar's Name (First, Middle, Last) UNKNOWN ELLA NORBACK SCOTT is marked or Thomas Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 : Miss Adrian J. Sarah 1908 Eastfield Road, Baltimore, MD 21222 Hem 27 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Mount Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 10/10/00 Baltimore, MD 21. Signature of Funeral Service License 22. Name end Address of Facility Kaczorowski Funeral Home, P.A. 23a. Part1. Enter the disease, or complications the ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. 1201 Dundalk Avenue, Baltimore, MD 21222 Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Tamponade Examiner Physician/Medical Examin The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immadiate ceuse. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. ed by the attending physician detached for use as the burial Hypertension
Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by ti 1 Yes 2 No 3 Probably 4 Unknown Cerebro vascular accident ģ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed Recurrent falls 20 No 1 Yes septial or Attending Physician: The hours after death.

Ineral Director: After this certificate y filled in by the funeral director, pa Be 25. Wes cese referred to medicel examiner? 26. Place of Deeth (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient edicai Certification: To 2 ER/Outpatient 3 □ DOA 27. Menner of De 1 Detural 2 Accident 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated.

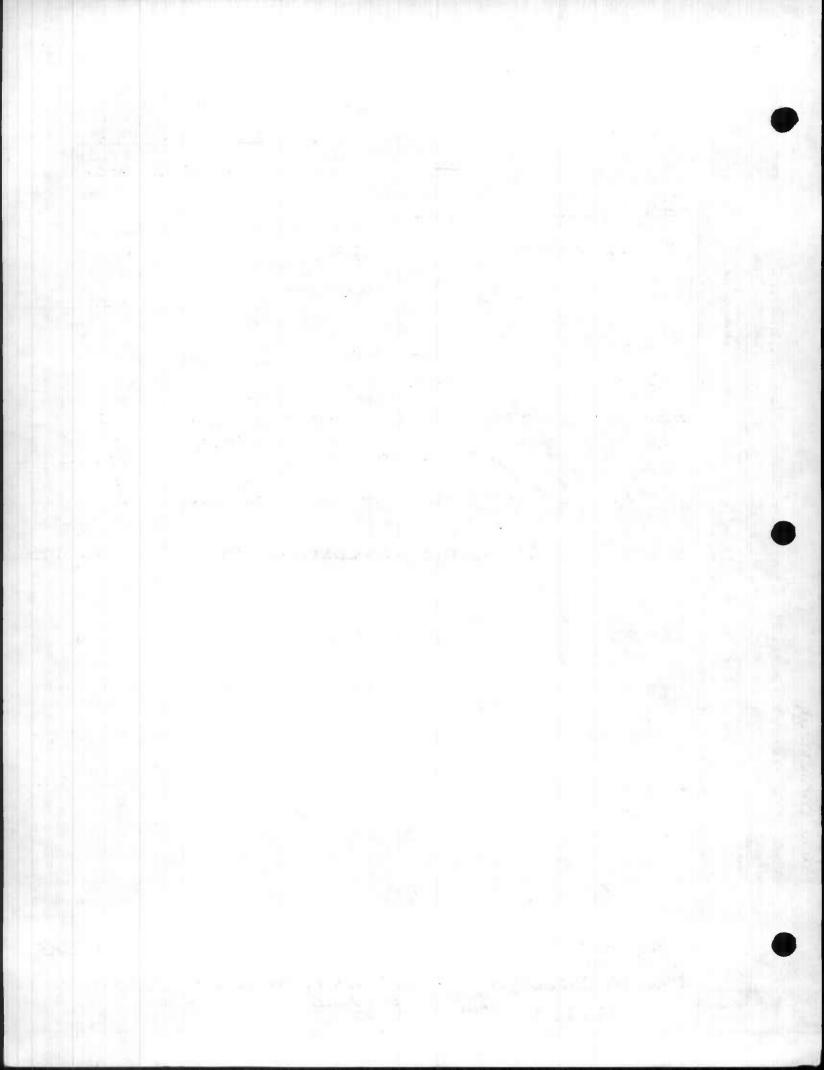
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a Certifier completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 20315 30. Name and address of person who completed ceuse of death (item 23a) (Type, Print) Riesett Kandal WD This Bayview 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

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	AMENDED ITE	M #7 PER FH G788 10	0/13/00 AH		Certifica	te of	Death		Reg. No.		
		1. Decedent's Name (First, Mid						2. Dete of D	eeth Dey	Year	3. Time of Death
	Physician /Medical	Marie	Ann		Danielo	czyk		October	^	2000	10:45 AM
	Examiner	4a Fecility Neme (If not institute	ion, give street end numbe	or)			4b. City, Town, or L			County of Death	TU:45 AM
		Charles Town	Care Center				Catonsvi	lle	В	altimor	re
	Funeral	5. Social Security Number		Age (In yrs. last b	Monthe	Days	r If Under 24 Hrs.		irth	9. Birth	nplace (State or Foreign untry)
-	Director	219-03-4952	1□M 2\(\(\)F	-89 - 81	Yrs.	Days	nouis Mill.	Sept.	26 19	19 Mary	zland
	2	Usuel Residence of Decedent									
	the Meryler 28a-f show notified at	10e. Stete 10b. Coun			wn or Location						10d. Inside City Limits
	r 28a-f sho	Maryland Balt:	imore	Caton	sville						1 ☐ Yes 2 ☐ No
	vith the Me t or 28a-f s be notified	10e. Street end Number			10f. Zi	p Code			10g. Citiz	en of Whet Cou	untry?
	th w	707 Maiden Ch	hoice Lane		2]	.228			U.S.	of Amer	rica
	filed within 72 hours efter death with the Meryland Hygiene. Hygiene. Indian "natural", or items 23s or 28s-f show ont, the Medical Exercites must be notified at a Completed by Funeral Director.	11. Meritel Stetus	12. Wes Deceder Armed Forces	nt Ever in U,S.	13. Wes Dece	dent of	Hispanic Origin? (Sp ban, Mexican, Puerto			4. Race - Amer	rican Indien,
0	or he	1 Never Merried 2 Me	erried 1 Yes 20] No		1000		o moan, etc.)		Black, White	, etc.
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2-0	ed within 72 hours ygjene. The Medical Exit, the Medical Exit.	15. Decede	ent's Education nest grede completed)	168	a. Decedent's Usi	el Occu	pation	tina	16b. Kin	d of Business/I	
2	di di	Elementery/Secondary (0-12)		r 5+)	life. DO NOT	ise retire	e during most of worked)	King			
2	d with giene.	12	NA	H	ome Make	er			OW	n Home	
2	be filed d other event, t	17. Father's Neme (First, Middle	e, Last)	11 - 12			18. Mother's Nem	ne (First, Middle			
Maryland	2 should be filed n end Mental Hygi is marked other raumatic event, To Be Co	Michael		Fere	nce		Rose			Kuzma	
6	d 2 shouth and M	19e. Informent's Neme/Reletion	nship (Type, Print)	19	b. Meiling Addres	s (Stree	et and Number or Ru	ral Route Num	ber, City or		
		Kenneth M. Dani	ielczyk (SON)	3	Farm Br	mk	Ct Down	Hall.	Mary	land 21	129
9	of Healt item 2	20e. Method of Disposition		20b. Place	of Disposition (Ne	me of		Date	7	ation - City or 1	
Baltimore,		1 Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other		0		otner pie	909)	October			
三	ritme ritme njur	21. Signature of Funeral Service	-/-	Oak	Lawn	nd Addr	ress of Fecility	14	Ea:	st Poin	t, Md.
Ba	permit. Peg Department Important: f any Injury o	10/ 11	71/11	/ /			rowski-Cho	oinacki	F.H.	S P.A.	
1		Mark	1. Con	ninch	100	5 Du	indalk Ave	a. Balto) Mc		
		23a. Part 1. Enter the disease, in hock or heart failure. Li	or complications that carbo st only one cause on such	ed the death. Do line.	not enter the mo	de of dy	ring, such es cardiac	or respiratory	errest,		Approximate Intervel Between
	Physician	and the second second	/								Onset end Death
	/Medical	Immediate Ceuse (Final disease or condition	Motors	statio	men	10	rmal	CA			mantha
	Examiner	resulting in deeth)	e. 1 1 C 1 C 1		consequence of		11100				1.01.11.0
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	be executed ician and burist-transit	Sequentially list conditions.	b	Due to (or es e	consequence of)	:					
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0	thet the death ce ed by the attendid deteched for use	Pert II. Other significant condit	tions contributing to death	but not resulting	in the underlying	cause g	Iven in Pert I.	-		,	to the cause of death?
1	thet the ed by detection							1	Yes 2/2	No 3□Pr	obably 4 Unknown
Vital Records,	The lew requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use as the burist-transit completed by Physician/Medical Examir							240 1440	e on eudona	24h V	Vere eutopsy findings
Ö	v requir							perl	s en eutops formed?	a	veilable prior to completion of cause
ec	npi npi									, 0	of death?
=	lclan: The lew require certificete hes been si rector, page 2 should							10	Yes 27	No 1	☐Yes 3☐No
ita	Physician: this certificated director,	25. Wes case referred to medic examiner?	al				26. Plece of Dea	th (Check only	one)		
of Vital Records,	2 00	1 Yes 2 No	Hospital: 1 ☐ Inpat	tient 2 ER/O	utpatient 3 D	OA OI	ther: 4 Nursing H	ome 5 Res	idence 6	Other (Spec	eify)
0	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	27. Menner of Deeth 1 ☑ Neturel 5 ☐ Pend	28a. Dete of In	jury 28b.	Time of Injury	28c. Inju	ury et	28d. Describe	how injury	occurred	
.0	Attending or death. octor: After by the fune filecation		tigetion	ay / o/	M		Yes 2□No				
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ā	no Hospital or Attending Ping At hours after death. The Funeral Director: After the pletely filled in by the funeral edical Certification:	Tomicide	building, e	etc. (Specify)				City of Te	own, Stete)		
	apita neurs nera / fille	29a. Certifier 12 Certify	ing Physician: To the besi	t of my knowledge	e, deeth occurred	et the ti	ime, date end place.	end due to the	cause(s) e	end menner es	steted.
	Fun Fun dic	(Check only 2 Medica one)	I Examiner: On the basis end menner s	of examinetion er	nd/or investigetion	, in my	opinion, deeth occur	rred at the time	, dete end p	plece, end due	to the cause(s)
	To the Hospital or Attend within 24 hours after deat To the Funeral Director: completely filled in by the Medical Certifical	29b. Signeture end title of certifi			29	c. Licen	ise number		29d. Date	signed (Month	n, Dey, Year)
-	F 3 F 3	No at	30	0			+ 000			100	
	0.7	Thylore		100		03	1890		000	ber 1	0005 1
	Y	30. Neme end eddress of person	n who completed cause of	death (Item 23a)							
		Myla M Co	urpenter	MD.	711 Ma	ide	in Choir	ce Lr	\ C	votoc	sille
7	State	31. Date liled (Month, Dey, Year		trer's Signeture		par					
N)	Registrar	OCT 1	3 2000	2761	ps	1000	-				



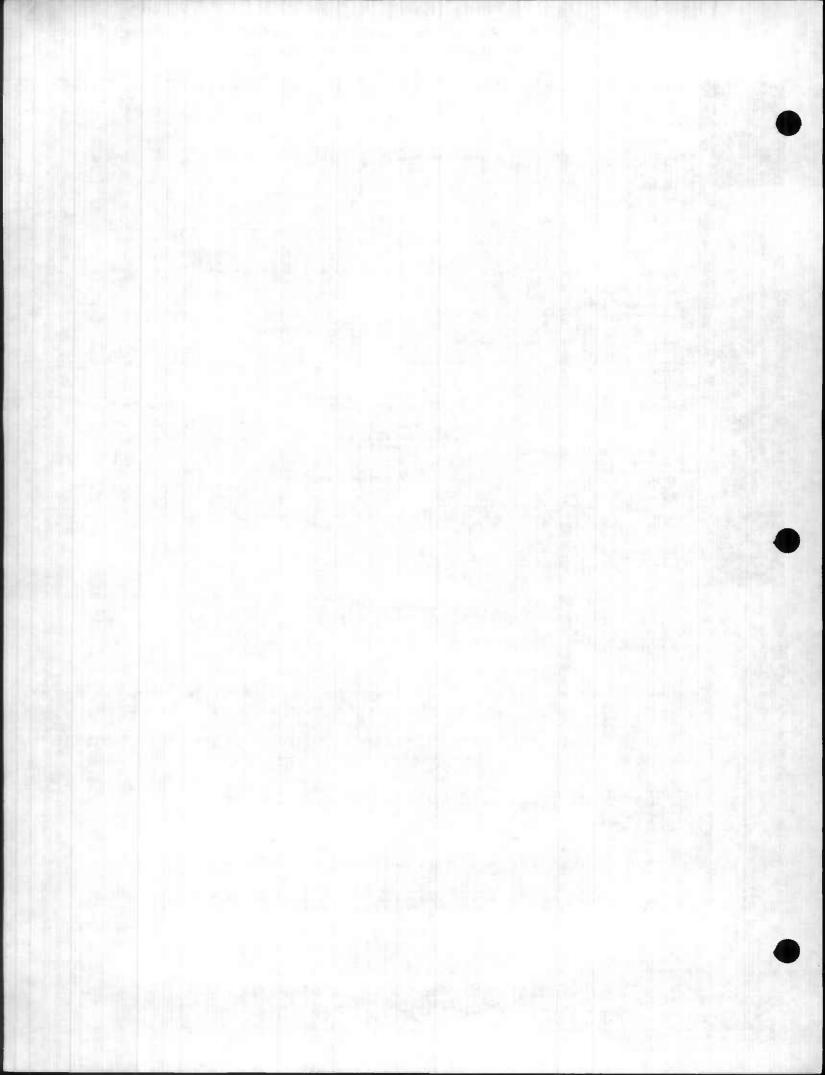
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State of Maryland / Department of Health and Mental Hygiene

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			(eπitica	te or	Death		Reg. No.		
Physician /Medical		•	Drager				2. Date of De Month Octobe	r 10	Year 2000	3. Time of Death 6:00 P.M.
Examine	An Contitue blooms (III mot Impaired on other		g Home		4	4b. City, Town, o	r Location of Deetl Dre		of Death imore	
Funeral Director	5. Social Security Number 6. Se 212 09 3283	ex 7. Aga □M 21X F	(In yrs. last birthe	Months	er 1 Year Days	If Undar 24 Hi Hours Mi		th y, Year) 1, 1912	9. Birthpl Count Mar	ace (State or Foreign ry) yland
Maryland 4 show led.st	Usuel Residence of Decedant 10a. Stata 10b. County Maryland Baltimore	re	10c. City, Town of Baltim						10	ld. Insida City Limits
or death with the Maryte therm 23e or 28e-f sho per must be notified at		oad		10f. Z	ip Coda 2120	7		10g. Citizan of V		ry?
urs after death vir. or flores 23s Statistics must	11. Maritel Status 1 ★ Nevar Married 2 Married	12. Wes Decedant E Armed Forcas? 1 ☐ Yes 2 ☑ N tt Yas, Giva Yaar or Datas:		It Yas, sp	edent of H		(Specify Yes or No arto Rican, atc.)	- 14. Race	a - Amarice k, Whita, a	
within 72 ho ens. than 'natura he Medical I		ucetion de completed) Collega (1-4or 5-	+)	ecedant's Us Give kind of w ife. DO NOT	ork done i use retired	durina most of w	rorking	16b. Kind of Bu		
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wells and in a 27 is ma		ippe, Print)	560	01 Chai	than	Road	Rural Route Numb	e, Mary	land	21225
tment of H tart: If Ne tjury or off	20e. Mathod of Disposition 1 🔀 Buriel 2 Cremetion 3 Classification 4 Donation 5 Other (Specify)	20b. Place of Cometery,	aven Me	emori	al Park	Deta 10/12/00	Glen B		, Maryland
Party in the same of the same	21. Signatural of Funeral Service Ulcen	Tonce				ss of Facility ie High	Gonce H way Balt	uneral i		
Sentificate be executed ding physician and ding physician and ding physician and as as the burial-transit physician and physician and physician and physician physician and physician phys	tmmediata Causa (Final disaesa or condition resulting in deeth) Sequentially fist conditions, if any, leading to immediata causa. Entar Undarlying Causa (Disease or Injury	b	Dua to (or as a co	nsequance of):	scase				
ding ding		d	Due to (or es e co	nsequance of):					
9 % #	Part II. Other eignificant conditions co	ontributing to death bu	t not resulting in t	he undarlying	ceusa giv	ran in Part I.	23b. Did tobecco use contribute to the ca			
200							24a. Was	1 Yee 2 No 3 Probably 4 C		
certificate has been s irector, page 2 should							10	Yas 2 No	of o	illable prior to oplation of ceusa laath?
is certifica director, I	25. Was casa ratarred to medical axaminar?	Hospitel:			Oth	nar:	eath (Check only			
His H	TLI TAS ZILIPINO	28a. Date of Injur (Month, Day	nt 2□ ER/Outp y Year) 28b. Tin	ne ot	28c. tnjur Wor	41 Nursing	Homa 5 ☐ Rasi 28d. Dascribe	dance 6 □Oth how injury occuri)
tal or Attending Physics after death. al Director: After this led in by the funeral d	3 Suicida 6 Could not be determined	28e. Pface of Injubuilding, atc	ry - At home, tarn (Specify)	n, street, facto	ory, office		28t. Location (City or To	Street end Numb wn, State)	er or Rura	Route Number,
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Medical Certil	29a. Certifiar 1 Certifying Phy (Check only one) 2 Medicat Exam									
To the Comp	29b. Signeture and title of certifier	i mo		29c. Licansa number 29d. Date signed (Month, Day, Year) D 4 7 6 8 3 10 11 00					Day, Year)	
2	30. Nama and addrass of person who complated causa of death (flam 23a) (Type, Print) Raymond Millio 25 Mari Educat Studie Zoo Ruskestown MS									
State	21 Date tiled (Month Day Veed)	32. Registre	r's Signature	Ang po	Loca	Ks.				



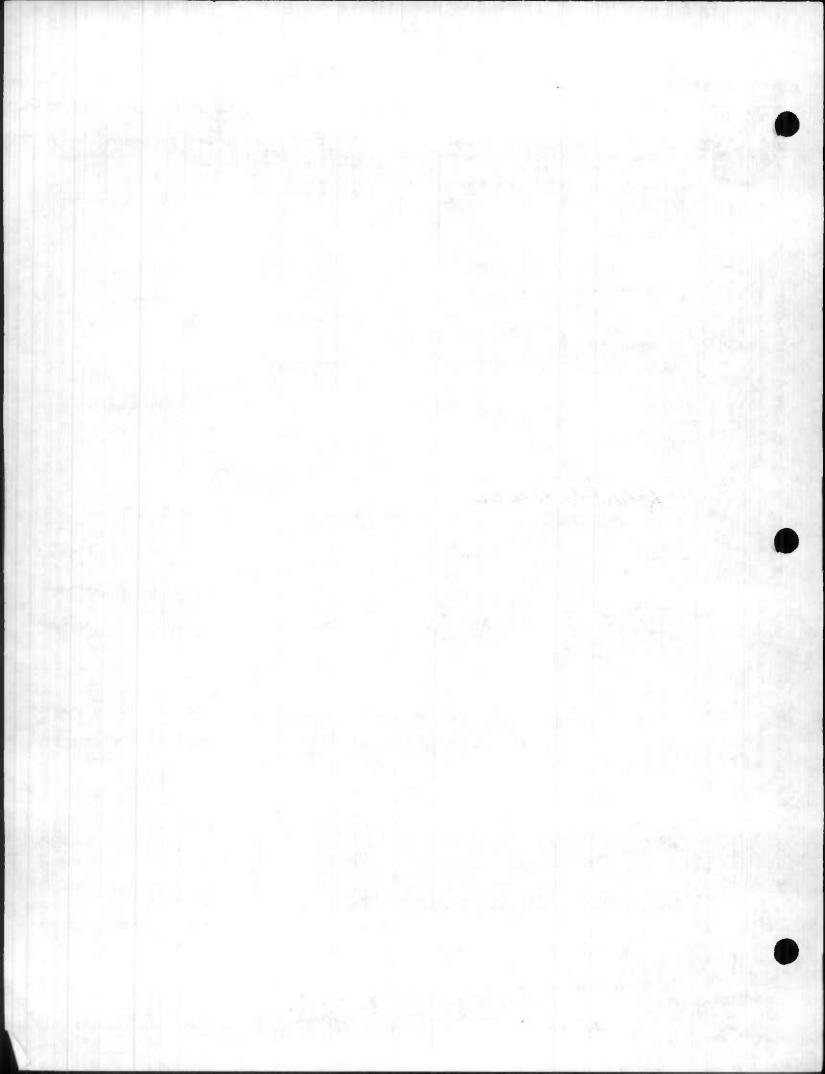
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

32359

				Certificate	UI Dealli		Reg. No.			
nysician	1. Decedent's Name (First, Middle,	Last)	_	1 .	8 1 1 1 6	2. Date of D Month	leath Day	3. Time of Death		
Medical	WO NA			elius		Octobe	r 11,	2000 10:30 A		
xaminer	4a Facility Name (If not institution,) Johns Hopk		tal		4b. City, Town	o, or Location of Dea		of Death limore City		
neral ector	5. Social Security Number 6. Sex 1 M 2 F 7. A(e (In yrs. lest birthday) 74 If Under 1 Year If Under 2 Months Days Hours		Min. (Month, D	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Followship) 9. Birthplace (State or Follow				
Important: If item 27 is marked other than "naturel", or items 23s or 25s-f show only injury or other treumatic event, the Medical Examination must be notified at an injury or other treumatic event, the Medical Examination must be notified at an injury or other treumatic event, the Medical Examination of the contract	Usual Residence of Decedent				103/21/			MD		
	10a. State 10b. County		10c. City, Town or Location					10d. Inside City Lim 1 ☐ Yes 2 ☑		
	MD Howard 10e. Street and Number		Ellicott City				40 000	H		
	3233 Birchmede Drive			21042			10g. Citizen of What Country? USA			
	11. Marital Status 12. Was Decedent I					? (Specify Yes or N		ce - American Indian,		
	1 ☐ Never Married 21 Married	Armed Forces? d 1 2 Yes 2 □ N	1 Yes 2 □ No		1 Yes, specify Cuban, Mexicen, Puerto Rican, etc.)			Black, White, etc.		
	3 ☐ Widowed 4 ☐ Divorced Year or Dates:						Specif	White		
	15. Decedent's Education (Specify only highest grade completed)		6	16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry			
	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Attorney			Private Law Firm			
	17. Father's Name (First, Middle, Last) 18. Mother's Name					Name (First, Middl	e (First, Middle, Maiden Surneme)			
	Charles C. Evelius Gertrude Brady									
	19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)									
	Mary Agnes Evelius Wife			3233 Birchmede Drive Ellic			ott City, MD 21042			
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State			Place of Disposition (Name of cemetery, crematory or other place)			20c. Location	- City or Town, State		
	4 □ Donation 5 □ Other (Spe	St. Jo	t. Johns Cemetery 10,			Ellicott City, MD				
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc.									
	736 Edmondson Ave. Baltimore, MD 21228 23a. Part Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									
	shock, or heart tellure. List only one cause on each line.							Onset end Death		
	Immediate Cause (Final disease or condition Cardiomyopathy							3 year		
	resulting in death) Due to (or as a consequence of):									
nine		■ b Co	ronary	Artery	Disease			20 years		
arending prysicen end for use as the burial-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Atherosclerosis Due to (or as a consequence of):							Unknown		
	thet initiated events resulting in death) Last	0	Due to (or as a co							
d for	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause							ntribute to the cause of de		
To the Functed Director: After this certificate has been signed by the attention property filled in by the funeral director, page 2 should be detached for un	Renal failure Hepatic failure					10	1 Yes 2 No 3 Probably 4 Unkr			
	TOWN 141107E 11EPACIE TAILORE									
						24a, Wa	is en autopsy formed?	24b. Were autopsy tindin available prior to completion of cause		
			- I	Bull I			,	completion of cause of deeth?		
	1)28						Yes 2□No	1 ☐ Yes 2 No		
	25. Was cese reterred to medical examiner? 1 Yes 2 No	Hospital:	26. Place of Death (Check only one) Ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
	27. Menner of Death		28c. Injury at Work? 28d. Describe how injury occurred							
	1 Natural 5 Pending 2 Accident investigat	Year) 28b. Tir	Injury Work? M 1 ☐ Yes 2 ☐ No							
	3 Suicide 6 Could no 4 Homicide determine	200. Place of injury - At nome, tarm, Street, tactory, onice					ation (Street end Number or Rural Route Number, or Town, State)			
	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner es stated.									
8		and manner sta	ted.			occurred at the time				
ledica	one)		29b. Signature and title of certifier 29c. License number					29d. Date signed (Month, Day, Year)		
Medica	one)	MD 0	l. 1 DI		DEC AA	0	10/1	1100		
Medica	one)	, MD Resid	dent Phys		RES-00	0	10/1	1/00		
Completely	one)	no completed cause of de	1	ician (ype, Print)		00 N, Wolfe				



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** 7 AN - NNA ARNELL ICTOBER 8 2000 /Medical MERCY HU.

7. Age (In yrs. last birthdey).

3.3 Yrs. 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner STELLA HOSPICE NIA MARIS TIMORE 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foraign Country) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 F 216-92-127 Director MAR Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ¥Yas 2 □ No Directo MARILAND 10e. Street and Number 10g. Citizen of What Country? 8 8 238 2122 ASTERY USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Wes Decedent/Evar in U.S. Armed Forces? 14. Rece - Amarican Indian, Bleck, White, etc. 11. Merital Stetus 1 Yes 2 No If Yes, Give Year or Datas: 1X Never Merried 2 Merried à Baltimore, Maryland 21215-0020 1 Yes 2 No þ 3 Widowed 4 Divorced ACK Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) WORKER AUNDRO MAT VEAR 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Pages 1 and 2 should be nent of Health and Mental ant: If Nem 27 is marked o JACOB MONROE OMAX 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Rdute Number, City or Town, Stete, Zip Code) AUDREV ENNALS 20b. Pleca of Disposition (Nema of cemetery, cremetory or other plece) BALTO. MD. 21229 CMOTHER MONASTERV 20a. Method of Disposition Data 20c. Location - City or Town, Stata Burial 2 Cremetion 3 Removal from State Capartment (10-14-00 BALTIMORE, MARYLAND (EMETERY 4 ☐ Donetien 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee BROWN FUNERAL 2140 MD. 2121 -ULTON AVE. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner or Attending Physician: The lew requires that the deeth certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Dua to (or as a consequence of): Box 68760, Due to (or es a consequence of) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Ware eutopsy findings available prior to completion of cause of deeth? Be Completed 24a. Wes an eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Wes case referred to medicel examiner? 26. Plece of Deeth (Check only one) STELLA MARIS Other: 4 Nursing Home 2 NO 1 Yas 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Sothar (Specify) HOS DIC Medical Certification: To 28c. fnjury et Work? 28d. Describe how injury occurred 27. Mermer of Death 28b. Time of 1 D Naturel 2 Accident 5 Pending after deeth. Director: Af 1 Yes 2 No Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a To the Funeral C Hospital tertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatura and title of certifier 30. Neme end eddress of person wh completed cause of deeth (Item 23e) (Type, Print) BAltiMORE 105

DHMH 16 Rev 6/95

State

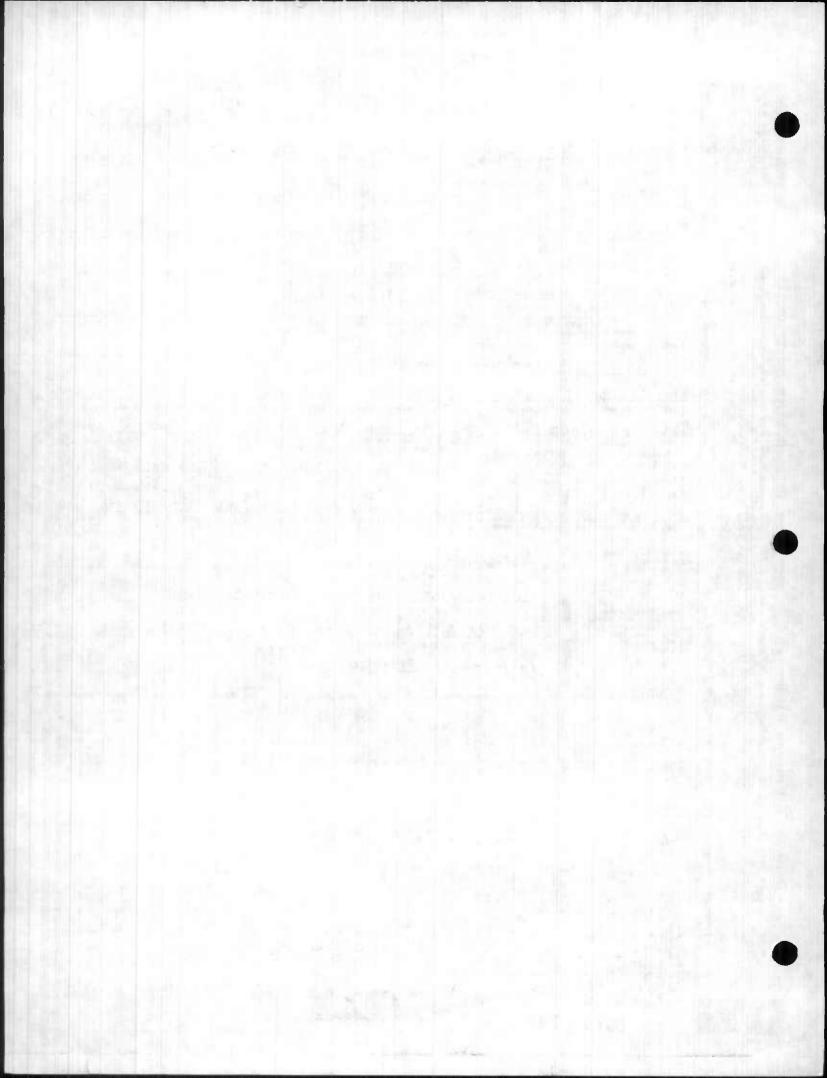
Registrar

31. Data filed (Month, Dey, Year)

3

2000

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** AUBREY FITZ GERALD 9:35 A.M. CTOBER 11 2000 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL HUNder 1 Year THE JOH.
5. Social Security Number HOPKINS JOHNS 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Months Days Min Hours 227-20-7778 74 Director LIECIALL Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Corroll FINKSbUrg ₹ Yes 2 No Nary/mo

10f. Zip Code

ENGINEER

20b. Place of Disposition (Neme of cametery, cremetory or other place)

Junes

Due to (or es e consequenca of):

21048

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lomans Court

52 40 ZEIS TENSTONN ROMO

Md 21215

CEMEtery

Boltmore,

ACUTE RESPIRATORY DISTRESS SYNDROME

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

23a or à

Director

Funeral

þ

Completed

10e. Street and Number

11. Merital Status

KATHY

4514 LEMANS

1 Never Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

Urughter

3 Widowed 4 Divorced

Elementery/Secondary, (0-12)

17. Father's Name (First, Middle, Last)

19e. Informent's Name/Relation/ship (Type, Print)

12 Burial 2 □Cremation 3 □Removal from State

RICE

12 12 grade

UNK.

20a. Method of Disposition

be filed within h and Mental t permit. Pages 1 and 2 st Department of Health and Important: If Nem 27 is n ò

21215-0020

Saltimore, Maryland

Box 68760.

P.O.

of Vital Records,

Division

Physician /Medical Examiner

The law requires that the death certificate be executed it or Attending Physician: The law requires the after death.

Director: After this certificate has been signe d in by the funeral director, page 2 should be a

completaly filled in by To the Hospital of within 24 hours at To the Funeral D

Physician/Medical Examiner Be Completed by Medical Certification: To

27. Menner of Deeth

1 Netural

2 Accident 3 Suicide 4 ☐ Homicide

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Delay Habis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1 Yes 2 No

SEPSIS Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): THROMBOCYTUPENIC 1010 PATHC Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. ACUTE RENT FAILURE 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end pleca, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the ceuse(s) (Check only one) end manner stated.

12. Was Decedent Ever in U,S. Armed Forces? 1DEYes 2 ☐ No If Yes, Give Year or Dates: WW.II

College (1-4or 5+)

29c. License number 29b. Signature end title of certifier Ruen ded no

RVS-000

29d. Date signed (Month, Day, Year)

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

MOEEN ABEDIN M.D. 600 N. WOLFE ST.

OCT 1 3 2000

32. Registrer's Signature sener

DHMH 16 Rev 6/95

State

Registrar

ORIGINAL

24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Was en eutopsy performed?

2 No

1 Yes

23b. Did tobacco usa contributa to the cause of death? 1 Yes 2K No 3 Probably 4 Unknown

10g. Citizen of Whet Country?

14. Raca - American Indian, Black, White, etc.

Specify; Black

16b. Kind of Business/Industry

FINGSBURG, Ded 21048

20c. Location - City or Town, State

KENBRIDGE, Virginia

Approximate Interval Between Onset end Death

24 HOURS

3 YEARS

HUNKS

U5B

18. Mother's Neme (First, Middle, Meiden Sumame)

Dete

22. Name and Address of Facility CHATM AT - Hom's Funeral Home

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)

Annie Mac Fitzgerald

1 ☐ Yes 2 No.

28d. Describe how injury occurred

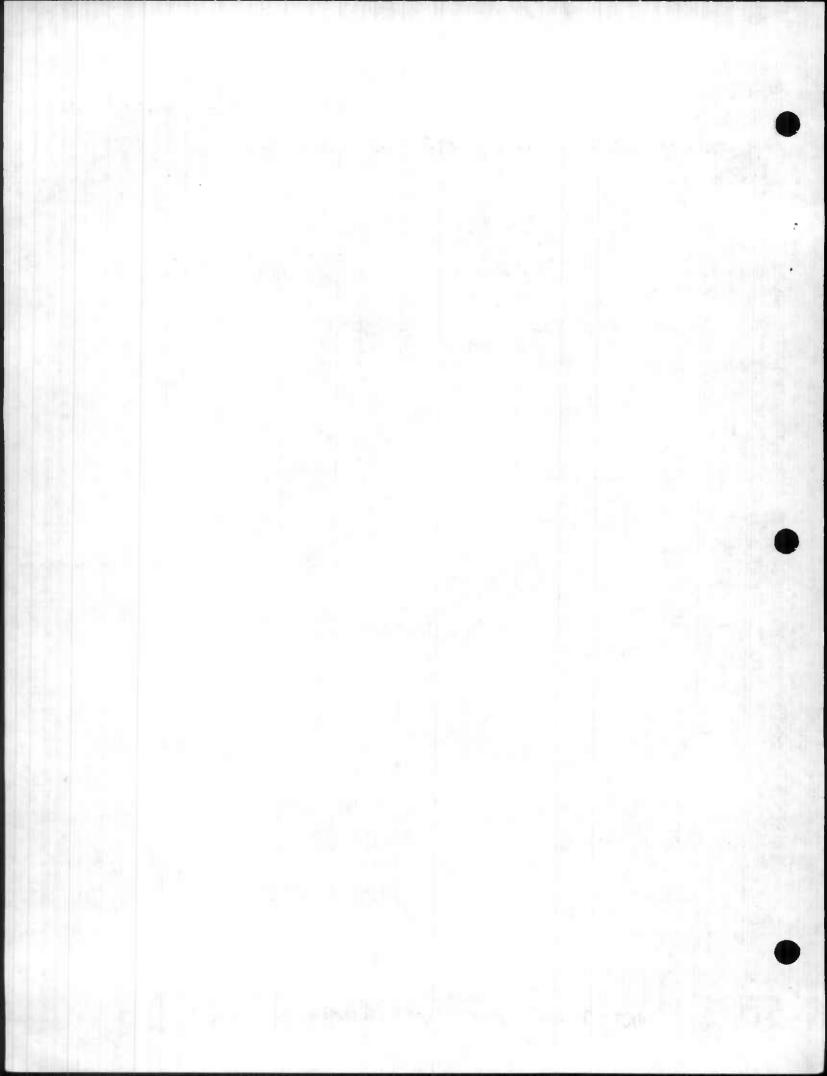
28f. Location (Street and Number or Rural Route Number, City or Town, State)

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11

BALTIMORE,

31. Dete filed (Month, Dey, Yeer)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32362 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Quella M. tock October 2000 4a. Facility Name (If not institution, give street and number) - Cronwell Center Balt moco 4b. City, Town, or Location of Death 4c. County of Death Eldercore Jenesis 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 1 M 2 N F Yrs. July 6, 1914 North Carolina 243-14-7763 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avenue).S. A. 5410 Dewalt 21206 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sermstress Lebo 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) O.B. Roberts emma Allan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald E. Ford -9707 Forge View Road Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland memorial Park 10/12/00 Parkville, Maryland 22. Name and Address of Facility

Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked other any injury or other traumatic event **Physiclan** /Medicai

Physician

/Medical

Examiner

10a. State

Director

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Completed

Be

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

e filed within 7 el Hygiene.

Maryland

the

Examiner

certificate be executed

Box 68760

P.O.

Records,

Division of Vital

bunel-transit and physician s the bunel 98 ettending for use es by signed b certificate has been si director, page 2 should I To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director, I

21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest,

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Approximately Immediate Ceuse (Final disease or condition resulting In death) Examiner Physician/Medical by Completed Be 2 Certification: 2 Accident 3 ☐ Suicide 4 Homicide

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

25. Was case referred to medical 1 Yes 2 No 27. Menner of Death 1 Neturel 5 Pending investigation

29a. Certifier (Check only one)

29b. Signature and this of certifies

Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end piace, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Due to (or as e consequence of)

Due to (or as a consequence of):

Due to (or es a consequence of):

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury et Work?

a End Stag

26. Place of Death (Check only one)

Other: 45 Nursing Home 5 Residence 6 Other (Specify)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23b. Did tobacco use contribute to the cause of death?

24a. Was an autopsy

1 ☐ Yes 2 No

28d. Describe how Injury occurred

1 ☐ Yea 2 ☐ No 3 ☐ Probably Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Approximate Interval Between Onset and Deeth

30. Name and address of person who completed cause of death (Item 23e) Type Print) then Poully, Bully Bulline, WSUSUL

State Registrar

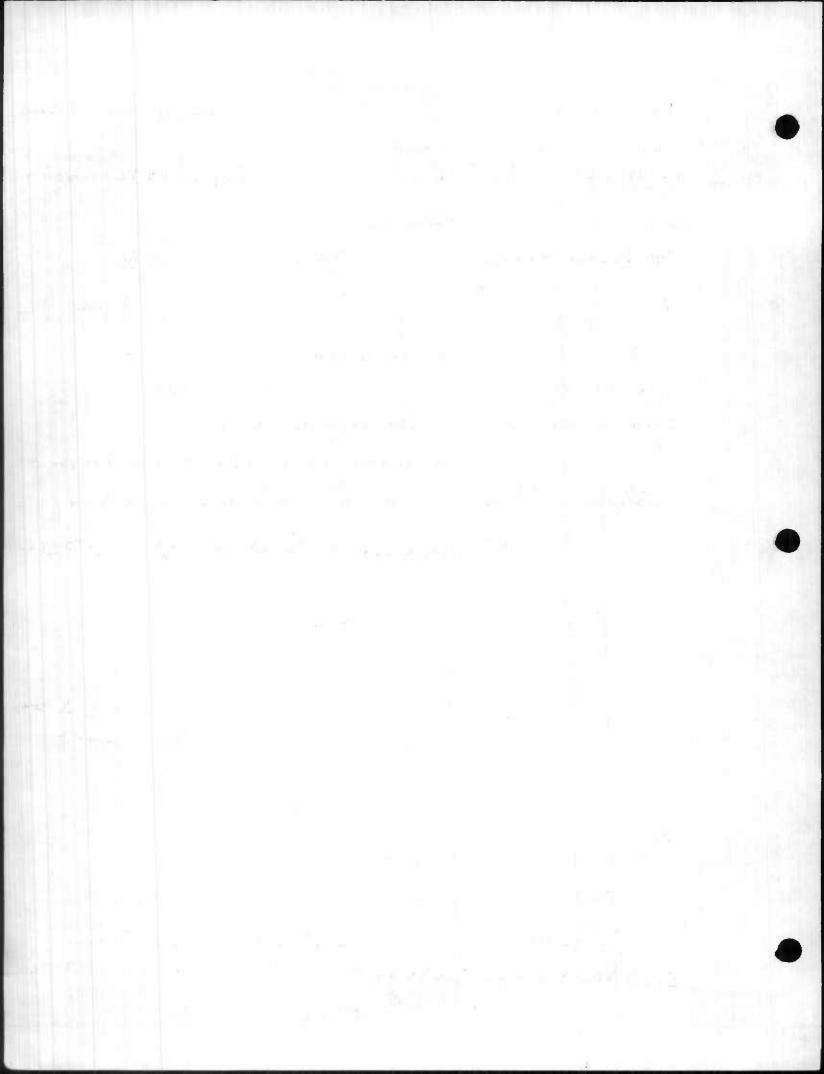
Medical

31. Date filed (Month.

6 Could not be determined

32. Registrar's Signature

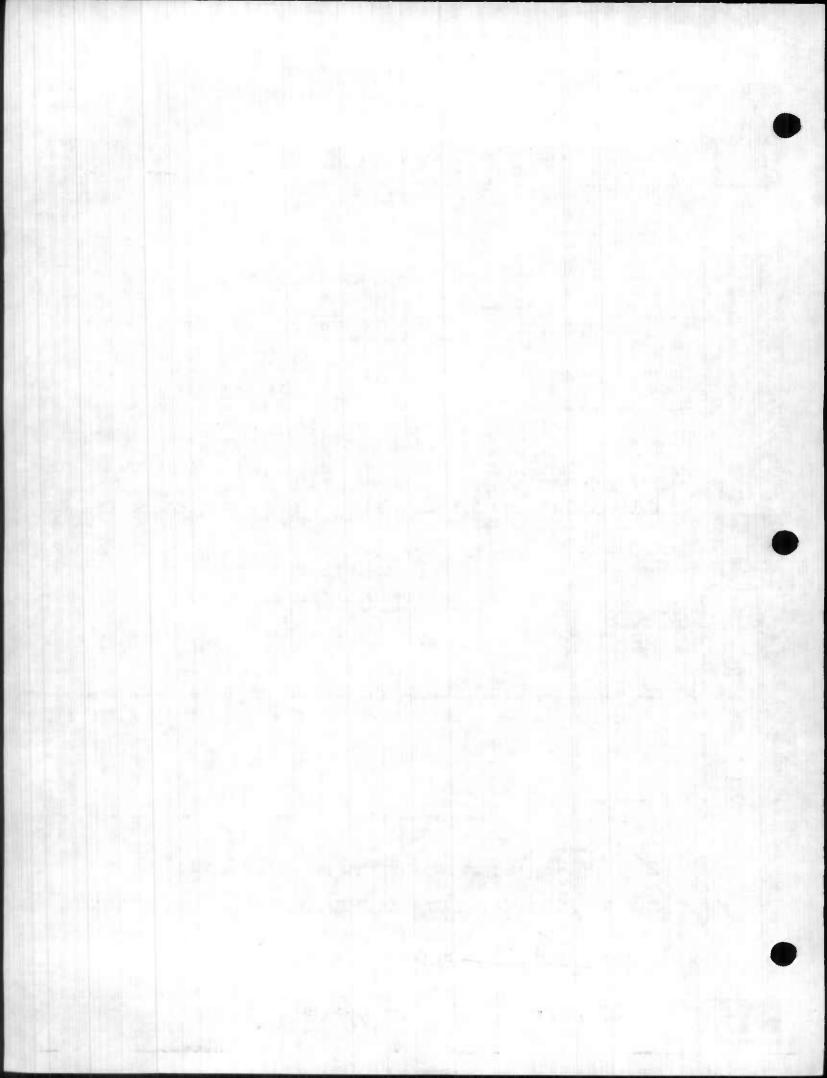
28a. Dete of Injury (Month, Day Year)



Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32363

	AMEND#8 PER F.H. G789 11-15-2000 JAB Cer	tificate of Death	Reg. No.	32363						
Physiciar /Medica	1. Decedent's Name (First, Middle, Last) MARY JANE FENWICK		2. Deta of Death Month Day Year OCTOBER 12,2000 4:00 am							
Examine	4a Facility Neme (If not institution, give street and number)	4b. City, Town, or Lo		Death						
Funeral Director	Fernbrook Assistive Living 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 162-05-7255A 1 M 3 TXF 95 Yrs.	# Under 1 Year If Under 24 Hrs. Months Deys Hours Min.	8. Date of Birth (Month, Dey, Year) 1914 9	Arundel Birthplece (State or Foreign Country) Pennsylvania						
	Usuel Residence of Decedent	· · · · · · · · · · · · · · · · · · ·	500. 10, 1504	remisyivania						
leath with the Maryland ma 23a or 28a-f ehow must be notified at	10a. Stete 10b. County 10c. City, Town or Loc		10d. Inside City Limits 1 ☐ Yes 2☐No							
vith the Mar	10e. Streel and Number	10f. Zip Code	10g. Citizen of Who	et Country?						
With the state of		21054	USA							
The Ren	11. Meritet Status 12. Was Decedent Evar in U,S. Armed Forces? 1 Never Merried 2 Married 11. Yes 2 No	Ves Decedent of Hispanic Origin? (Spe Yes, specify Cuben, Mexican, Puerto I		American Indien, White, etc. White						
27 2 2	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 1 Homem	ent's Usual Occupetion kind of work done during most of workin DO NOT use retired)								
			Own Hor (First, Middle, Maiden Sumeme)							
E Saby	Occan A Chiller	Amelia 1								
laryla should and Men marke		g Address (Street end Number or Rure	I Route Number, City or Town, St	ate, Zip Code)						
CENE	William Fenwick (Son) 1678	Justin Drive, Gaml	orills, MD 2105	4						
8 5 5 0	20e. Method of Disposition 1 Burial 2 X Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 20b. Place of Disposic cemetery, crem Metro Cre	natory or other place)	Dete 20c. Location - Ci							
Baltimo pemit. Page Department of Important: if any Injury or	21. Signeture of Funerel Service Licenses 22.									
	23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter shock, or heart tellure. List only can cause on each line.	, Annapolis, MD respirelory arrast,	21401 Approximete Intervel Between							
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) Parkinson's limited as a limite			Onset and Deeth 4 years						
68760, ilicate be executed g physician and as the bunial-transit	Due to (or es a consequenca ot): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequenca of): Due to (or es a consequenca of): Due to (or es a consequenca of):									
	d									
the death certify the attending sched for use a	Part tt. Other significant conditions contributing to death but not resulting in the un	odertving cause given in Pert I	23h Did tobacco use contr	ribute to the cause of death?						
Or the party of	Bilateral Carotid Stenos.			B □ Probably 4⊠ Unknown						
of Vital Records, P Physician: The law requires that this certificate has been signed be ral director, page 2 should be deter	Peripheral Vascular Dise	ase	24e. Wes en eutopsy eveilable prior completion of of death?							
The late he page			1 ☐ Yes 2 2 No	1 ☐ Yes 2 ☐ No						
Vital I		26. Place of Deeth								
Of Vita Physician: this certific ral director.	1 Inpatient 2 EH/Outpetien		me 5 ☐ Residenca 6 ☑Other							
OIVISION or Attending after death. Director: After lin by the fune	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street building, etc. (Specify)	Work? M 1 Yes 2 No	28d. Describe how Injury occurred Living 28t. Location (Street end Number or Rural Routa Number, City or Town, Stete)							
in 24 hours in 24 hours he Funeral pletely filled		occurred et the time, dete and pleca, eastigation, in my opinion, deeth occurred	and due to the cause(s) and menr ed at the time, date end pleca, an	ner es stated. d due to the cause(s)						
To the To the comple	29b. Signeture and little of certifier will will m-D.	29c. License number D0014160	29d. Date signed ((Month, Day, Year)						
4	30. Name end address of person who completed cause of deeth (Item 23a) (Type, I Harjit Singh, M.D. 5410-A									
State	31. Deta filed (Month Pers) 32. Register's Signeture	Ritchie Highway	Baltimore, N	Ma. 21225						



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32364 Certificate of Death 2. Data of Daath 3. Tima of Death 1. Decedant's Name (First, Middle, Last) 4b. City, Town, or Location of Death 4c. County of Death Facility Name /ff not institution, give street and number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) MARYLAND 7. Age (In ers. last birthda 10 M 20 F Months Days Hours Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE CITY 1 XYes 2 □ No MARYLAND 10e. Street and Number og. Citizen of What Country? I BERTY HGTS 401 2120 USA. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ≥ Yes 2 □ No If Yes, Give Year or Dates: 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yas 2 No Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ZYRS OFFICER POLICE DEPARTMENT 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middle, Last) FREEMAN JOSEPH MARGIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6036 CHESWORTH RD. CATONSVILLE MD 21228 pa of Disposition (Name of Date 200. Location - City or Town, State (SON) KEITH FREEMAN 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State METRO CREMATORY 10-10-00 BALTIMORE, MD 4 Donation S ☐ Other (Specify) 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIHORE, MD. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, Approximate Alkero Scieno la Cardiovasculas Digeuse Immediate Causa (Final disease or condition resulting in death) Ob melie Pulminas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? Deventia 3 Probably Unknown 1 ☐ Yes 2 ☐ No bladder Carcinne 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy Winary 2DNo 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner Examiner

Physician /Medical

Examiner

Directo

Funeral

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Completed

Be

2

Director

7 is marked other than "natural", or itema 23a or 28a-f traumatic svent, the Medical Examinar must be northe

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within insert of Health and Mental Hygiene.

Physician

/Medical

the esn

ician and burial-trans physician signed by funeral after death.

Division of Vital Records, P.O. Box 68760

or Attending Physician:

24 hours a Hospital

To the Vithin 2

Physician/Medical Completed by Be P Certification:

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

5 Pending Investigation

28a. Date of Injury (Month, Day Year) Could not be determined

28b. Time of

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 2 No 1 Yes

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stata) **Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifie

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29c. License number 30641 29d. Date signad (Month, Day, Year) October 10 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ramesh Sahapalhi 200-109 Back Muer Week 10 Balline MD 2/22/

Registrar

X

Medical

31. Date filed (Month, Day, Year)

Olan

32. Registrar's Signature

A STATE OF THE Swediesell Bester ame BANTHORE CITY 4617 LIDSUT/1635 THE CIFICES PEUD DEPARTMENT COLLINS PHAKEE SCEENIAN KEITH PRESERVE LOOK COSE CHEETHORTH KE SHE SWILLENDERRED METRO CREMATERS STATE LAST PORCE FIR Street in the second to the second device of the second se

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** COOBER 9:18 A.M 2000 Violet Johanna Germeroth /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KOSEDALE BALTIMORE FRANKLIN SQUARE HOSPITAL CENTER 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sax Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M XX Yrs. 79 219-44-8292 12/3/1920 **Director** Rossville. MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas ZONo MD Harford Joppa Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ò 238 502 Echols Court Funeral 21085 USA 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Yas 2 No If Yes, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 Yas 2 No ò 21215-0020 Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 years N/A Housewife her own home Maryland 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) ould be Mental John Herman Mohr Myrtle Wilhemina Kuehne 19a. informant's Name/Reletionship (Type, Print) 19b. Melling Addrass (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 3 David Germeroth 502 Erickson Court Joppa octant: If Hem 27 ,Md 21085 Saltimore, 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Pages 1X Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Meadowridge Memorial Park Cemetery 10/11/00 Howard County 22. Nama and Addrass ot Facility E.F.Lassahn Funeral Home - dassaks 11750 Belair Rd. Kingsville, MD 21087 23a. Parti. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart teilure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** Immediata Causa (Final disaasa or condition resulting in deeth) /Medical ACUTE MYOCARDIAL INFARCTION Examiner Dua to (or as a consequence of): Examiner ATHEROSCLEROSIS The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disaase or injury that initiated evants resulting in death) Last Dua to (or as a consequence ot) Box 68760, Physician/Medical the Dua to (or as a consequence ot) USB BS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? P.0. 1 Yes 2546 3 Probably 4 Unknown Records, ρ 99 24a. Was an autopsy performed? 24b. Ware autopsy tindings available prior to completion of cause of deeth? page 2 should Be Completed certificate has 1 Yas 2 No 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was casa ratarred to medical 26. Placa of Daath (Check only one) axaminar? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Medical Certification: To 28a. Deta of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred Division or Attanding 5 Pending invastigation Netural after death. Director: Af 1 Yas 2 No 2 Accident the 28a. Pleca of Injury - At homa, tarm, street, tactory, office building, etc. (Specify) 3 Suicida 6 Could not be 28t. Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 Homicida 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and menner es steted.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier compietely (Check only one) and manner stated. To the Vithin 2 29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year)

DHMH 16 Rev 6/95

GEREMEROTH,

State Registrar

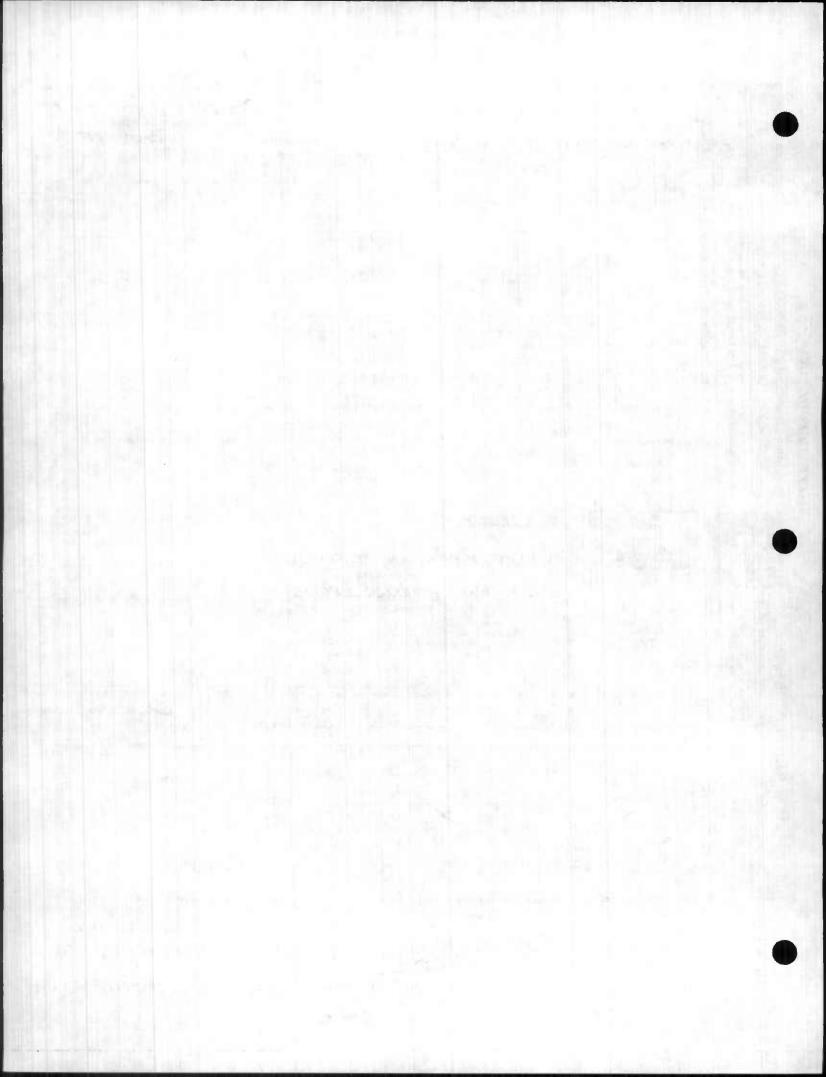
31. Data filed (Month, Day, Year)

4 and address tri person who completed cause of daath

9105 FRANKLIN SQUARE DRIVE SUITE 106, BALTIMORE, MD 21237 TECKLENBERG, M.D. 32. Registrar's Signatura Sanera

OCTOBER 10, 2000

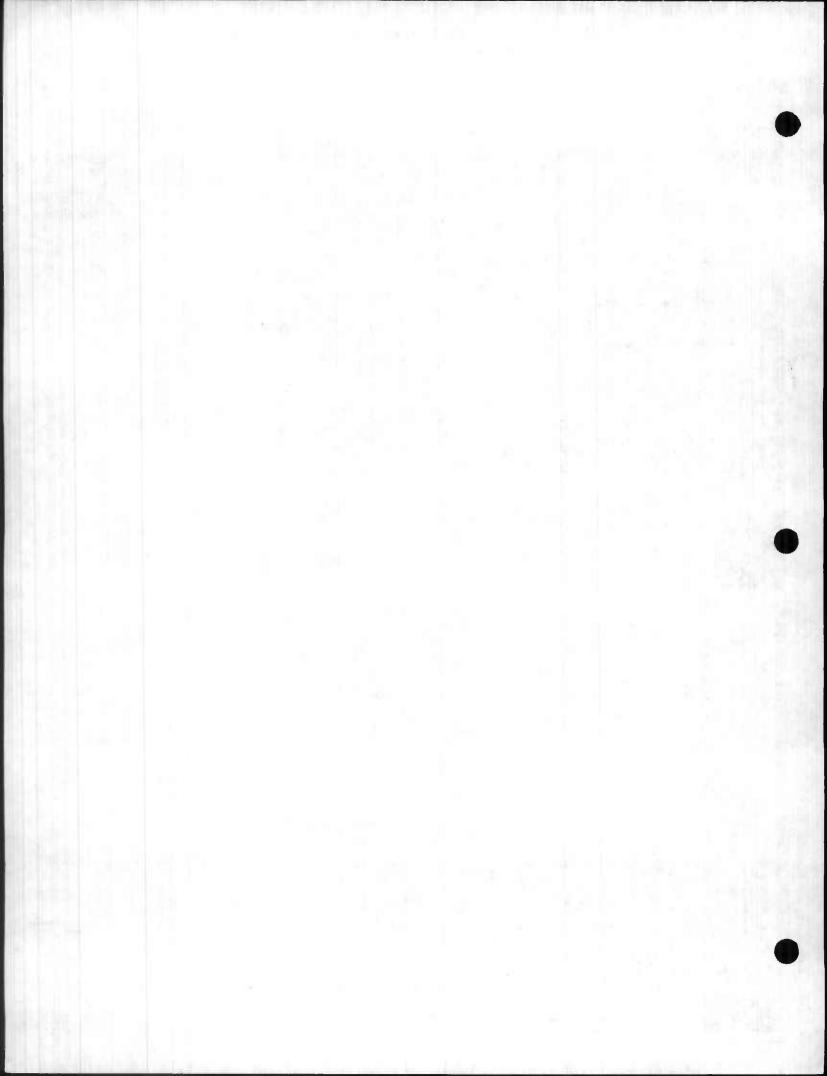
(Item 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 3 6 6

DOLORES	M.	GAWOR

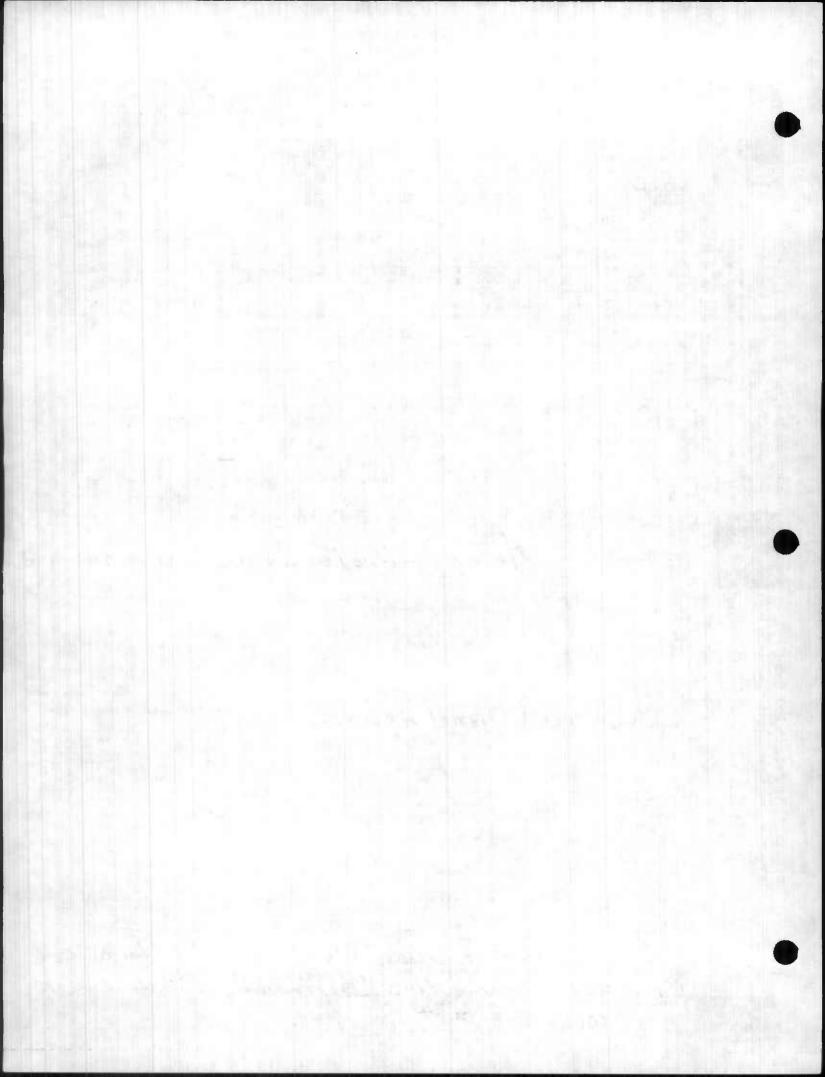
DOLORES M.	GAWOR			Ce	rtificate	of I	Death			Reg. No.			
100	1. Decedent's Name (First, Midd	e, Last)							2. Data of De Month		Yaar	3. Time of Death	
Physician /Medical	TALLUDES I CAMUD									8, 2		0902 AM	
Examiner	As Couldn't higher (If not institution also street and grapher)										County of Dea		
AT-											N/A		
Funeral	5. Social Security Number	6. Sex 1 M 2 F	7. Age (In yrs.		Months	Days	If Under Hours	Min.	8. Date of Bi	ay, Year)	C	rthplace (State or Foreign ountry)	
Director	214-24-4372 Usual Residence of Decedent		/	73 Yrs.		-			8/19/	21	MAI	RYLAND	
fand fand	10a. State 10b. County 10c. City, Town or Location											10d. Inside City Limits	
Men Help	MD I	N/A		BA	ALTIMOH	RE					1 ¥Yes 2 □ No		
vith the Mer or 28a-f s	10e. Street and Number			11-11	10f. Zip C	ode	E			10g. Citiz	ountry?		
h wit		710 SOUTH LINWOOD AVE. 21224								USA	A		
fer deeth with the Menylan freme 23s or 28s-f show the crisis be notified as	11. Marital Status 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yas, specify Cuban, Mexicen, Puerli							gin? (Sp	ecify Yes or No Rican, atc.)	0- 1	4. Race - Am Black, Whi		
or in		ried 1 Tyes	2 No		1 Yes 2		Spacify:				C/6		
Maryland 21215-0020 d 2 should be filed within 72 hours efter death with the Meryland at 5 should be filed within 72 hours efter death with the Meryland th end Mental Hygiene 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at To Be Completed by Funeral Director		Yaarorl									Y	WHITE	
ed within 72 ho ygiene. For then "natur. It, the Medical. Completed	15. Deceder (Specify only highe	it's Education st grade completed)	(Give	dent's Usual kind of work DO NOT use	dona	during mos	t of work	ing	16b. Kir	d of Business	sindustry	
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and 2 be filed ntal Hygin d other event, ID		-		COSI	OMER :	DEK.		r's Name	e (First, Middle	1			
ylanc buid be fi Mental H mrked out	STEPHEN F. M	AKOWSKI					SOPI	HIA	BEJMA				
Maryla d 2 should th end Men 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of								per, City or	Town, State.	Zip Code)	
CZNL	MRS. NANCY JEST	TER		115 H	HOLLY (CIR	CLE B	ALTI	MORE, M	D. 2	1221		
DE STEE	20a. Method of Disposition 20b. Place of Disposition (Name of								Date 20c. Location - City or Town, Stete				
Baltimor permit. Pages Department of Important: If he any folury or o	1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ST. STANISLAUS CEME. 10/1									BAL	TIMORE,	MD.	
Balt Separting Moort any Inje	21. Signatura of Funarel Sarvice	Licensee		2	2. Name and	Addre	ss of Facili	ly					
00 88 5 8 8	Charles facyorowski KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD.											222	
	23a. Part1. Enter the disease, o shock, or heart tailure. List	complications that	ceused the deat	h. Do not en	ter the mode	of dyir	ng, such as	cardiac	or respiretory	arrest,	VID - 2 2	Approximata Interval Batween	
Physician												Onset and Death	
/ /Medical Examiner	Immediata Causa (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease												
	Due to (or es a consequence of):												
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P.O. at the distribution of the distribution o	Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I.								1 Yes 2 No 3 Probably 4 Vun				
* = 90 >						_							
Cords requires been sign should be										s an eutop	sy 24b	. Were autopsy findings available prior to	
Recc e law re hes be pe 2 sh							-		INSE	PECTIO	NC	completion of ceuse of death?	
The law require tale has been signed about Completed									10	Yes 25	No	1 ☐ Yes 2 ☐ No	
of Vital Record Physician: The law require this certificate has been signal director, page 2 should in To Be Completed	25. Was casa raferred to medica examiner?	1					26. Place	of Daet	h (Check only	one)			
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Jing Ph After th funeral	27. Mannar of Death 1 Naturel 5 Pendin	28a. Data (Mo	of Injury oth, Day Year)	28b. Tima o Injury	1	c. Injur Wor			28d. Describe	how injury	y occurred		
Attending at death. Ctor: After by the fune lifecation	2 Accident Invastigation M 1 Yas 2							No	ORt Location	/Chanadan	d Mirahara e	Dural Pauta Mumbar	
Division of the or attention of the funeral or attention of the funeral or attention of the funeral or attention or attent	4 Homicida determ	ined 200. Plac	e of Injury - At he ding, atc. (Specif	ome, fam, st y)	reat, factory,	office			City or To	own, State,) Number or i	Rural Route Number,	
	29a. Certifier 1 Certifyi	a Physician: To th	a hast at my kno	urladas dest	h oncurred at	the tir	ma data an	d place	and due to the	coura(c)	and manner	as stated	
w Hospital n 24 hours u w Funeral pletely filled		g Physician: To th Examiner: On the l end ma	basis of examina nnar stated.	ition and/or in	vestigetion, i	n my o	pinion, das	ith occur	red at the time	, date and	place, end du	ua to the cause(s)	
within 2 To the comple	29b. Signatura and title of certifie		That office.		29c.	Licans	a number			29d. Date	a signed (Moi	nth, Day, Year)	
F 3 F 8	1000	16.0				0.0	C.M.E		12	O	CT. 8	, 2000	
16	30. Name and address of person who completed cause of death (frem 23a) (Type, Print)												
	Dennis Chute			Notice of the second		et	Rali	timo	re, Mar	vlan	3 2120		
State	31. Data filed (Month, Day, Year,		Registrar's Signa	ature	A	-			LO, IMI	Jacan	- alau		
Registrar	ôôT	1 3 2000	Bens	MAN .	P.	14	acks						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	Amended :	State of Maryland / Department of Health and Item#20b perFHG788 10/13/2000 EW Certificate of Death	Reg. No.
į.	Physician /Medical	1. Decedent's Name (First, Middle, Last) KAYCELE S. GOLDMAN	2. Date of Death Dey 1, 2000 9:15PM
ŠL.	Examiner	9813 MIDDLEMILL DRIVE OWINGS I	
	Funeral Director	5. Sociel Security Number 219-26-4963 6. Sex 1 Months 7. Age (In yrs. last birthdey) 65 Yrs. 65 Yrs. 65 Hours Mir	
pulgend	show dat	10a. Stele 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☐ Yes 2 🕅 No
No M	or 28a-f s be notified Director	MD BALTIMORE OWINGS MILLS	
6 40		9813 MIDDLEMILL DRIVE 10f. Zip Code 21117	10g. Citizen of What Country? U.S.A.
020 curs after de	Example must	11. Maritel Stetus 1 Never Merried 2 Married 1 Never Merried 2 Married 3 Widowed 4 ZiDivorced 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Specify Cuban, Mexicen, Pue 1 Yes, Sive Yeer or Dates:	Specify Yes or No- rio Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0020 d within 72 hours at	or than "natural, the Medical.	15. Decedent's Education (Specify only highest grade completed) Elamantery/Secondery (0-12) College (1-4or 5+) 2 16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired) HOMEMAKER	orking 16b. Kind of Business/Industry OWN HOME
	d other event, Be C	1200 0200 00 00 0000	ame (First, Middle, Meiden Surname)
Maryland	Menta Markad netic er To E	M. MICHAEL GREENBERG HILDA	KLAVENS
Maind 2 of	27 is n 27 is n r traun		Rural Route Number, City or Town, Stete, Zip Code) AD - REISTERSTOWN, MD 21136
Pages 1 a	nent of He int: If hem iry or othe	20a. Method of Disposition 1 Burial 2 M Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Neme of cemetery, crematory or other place) HILLTOP SERVICE CORP.	Date 20c. Location - City or Town, State 10/ 10/ 00 TOWSON, MD
Balt	Departs imports any inh ance.		DL LEVINSON & BROS., INC. ROAD - PIKESVILLE, MD 21208
Ex.	ysician Medical caminer	Immediate Cause (Final disease or condition resulting in death) List only one ceuse on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	rdio Vascular Disesse
.O. BOX 68760, the death certificate be executed	1 by the attending physician and etsched for use as the burial-transit.	Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
de at	ed for	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Dfd tobacco use contribute to the cause of death?
T at	igned by the be detached by Physic	Chronice Ethanol Abuse	1 Yes 2 No 3 Probably 4 Unknown
Records, The law requires ti	2 should		24a. Wes an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth?
= F	page 2		1 Yes 2
Vital	entific ector	examiper?	eath (Check only one)
o de	To To	27. Mannar of Death 1 Reviatural 5 Pending 28a. Dete of Injury 28b. Time of 28c. Injury at 28b. Time of 28c. Injury at 28c. Injury 28b. Time of 28c. Injury at 28c. Injury 28c. In	Home 5 Describe how injury occurred
Division or Attending	rector: by the	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Hospital	within 24 hours at To the Funeral Di completely filled in Medical Cel	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plated the composition of the composition of the pasts of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date and plated the plate of the	
To the	To the comple	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	Q	Charlest ODonnella D-0938	3 4 1000 8,2000
(0	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	thill Rd and 21210
	State Registrar	00T 13 2000 > Beneva & Sparks	

ORIGINAL

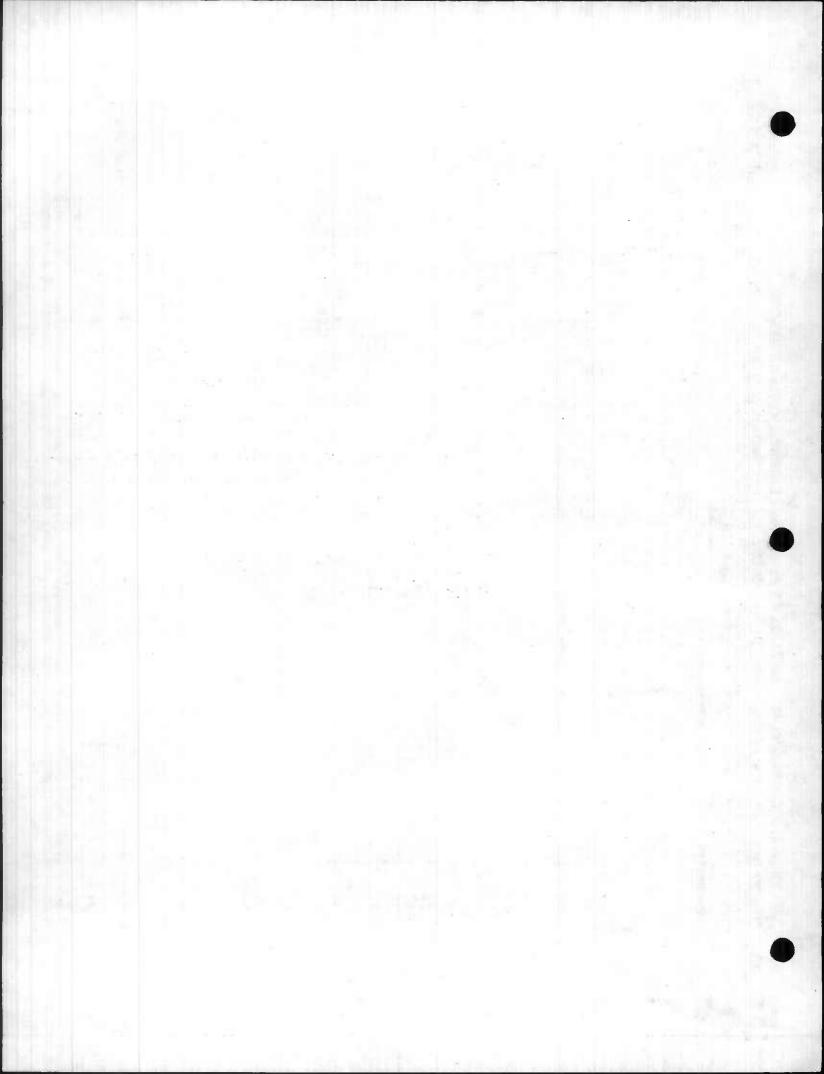


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State of Maryland / Department of Health and Mental Hygiene 32368 Amend Item 26 per phy, 788,10/13/00dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** Samuel D. Godwin III October 0 4 2000 12:14 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Harbor Hospital Center Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Hours Months 218 44 1456 Yrs. 52 Director Sept. 30, 1944 Maryland Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 13 Yes 2 □ No N/A Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1319 Patapsco Avenue 21225 U.S. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Health Emerican Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Clerk Medical Sales years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Winnifred Thompson Samuel D. Godwin Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 3105 Garden Court St. Cloud, Florida 34769 Constance Godwin Dete 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/9/00 Baltimore, Maryland Woodlawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Line Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part 1. Enter the disease, or complications that caused the dhalfs. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate tnterval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical o cold Examiner Due to (or as a consequence of): Examiner en LION The law requires that the death certificate be executed physician and s the burial-trans Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) 838 980 ŏ P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 1 ☐ Yes 2 NiNo 1 □ Yes 2 □ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Surring Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 2 ER/Outpatient 3D DOA this 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Netural 2 Accident after death.

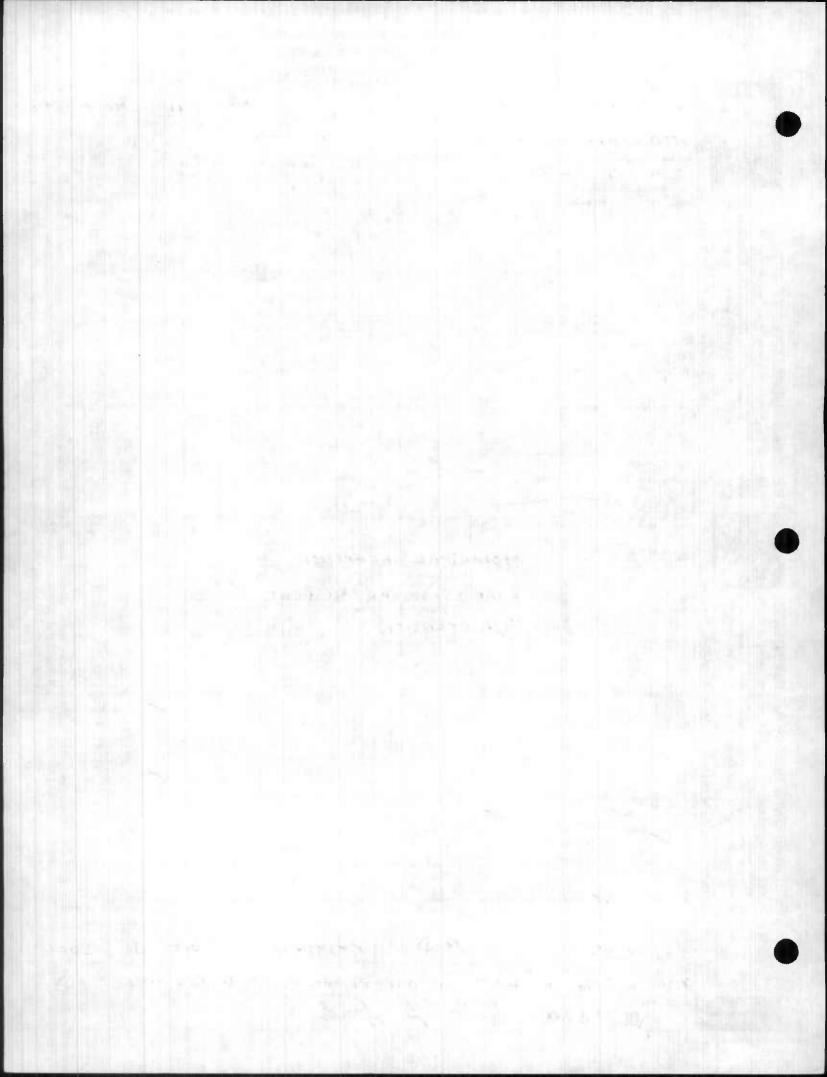
Director: Aft
d in by the fur 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 24 hours after Funeral Directles detely filled in b after To the Hospital o within 24 hours at To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 50470 00 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1319 light 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 3 2000 Registrar



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	Certificate	e of Death	Re	g. No.	02000					
Physician	1. Decedent's Nama (First, Middle, Last) WALTER GEER		2. Date of Death Month	Day Y	3. Time of Dear					
/Medical		4b. City, Town, or L	OCT	4c. County of	coo 23:4					
Examiner	4a Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL	BALTIMOF		NA						
Funeral	Social Security Number Social Security Number	1 Yaar If Undar 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplaca (State or For					
Director	242-09-3071 19√ M 2□ F 83 Yrs. Months Usual Residence of Decedent	02-18-	-17	NC						
show Mail	10a. State 10b. County 10c. City, Town or Location				10d. Insida City Lin					
23a or 28a-f showing the morning and the morni	MD NA Baltimore		1 Yes 2							
or 28 Direct	10a. Street and Number 10f. Zip		10	g. Citizen of Wha	t Country?					
e 23a met	1658 E. Belvedere Avenue Apt.#	21239	noity Van as No	USA	American Indian,					
"natural", or flems 23a or 23a-fis folicis Exercipes must be nothinal letted by Funeral Director	1 Nevar Married 2 Married 1 Yes 2010	dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto XIX No Specify:	Rican, etc.)	Black, 1	White, etc. Black					
ygiene. er than "naturn r, tre trouces Completed	15. Decedent's Education 16a. Decedent's Usua (Specify only highest grade completed) (Give kind of wor	al Occupation rk done during most of work se retired)	rina 1	6b. Kind of Busin	ess/Industry					
than the plant	Elementary/Secondary (0-12) College (1-4or 5+)				Elec					
filed within 72 hours after deeth with the Meryland Hygiene. friber than "natural", or flams 23a or 28a-f show ent, the Medical Exerciper result to notified a 9 Completed by Funeral Director	6th Grade NA Mainter 17. Father's Name (First, Middle, Last)		e (First, Middle, M		re Gas &					
marked other than marked other than matte avent, train To Be Comp	James Bennett Geer	Rebecca		Mangum						
2044	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	(Street and Number or Ru	ral Route Number,	City or Town, St	nte, Zip Code) 212					
		6910 Lachlan Circle Apt.I Baltimore								
of F y	20a. Method of Disposition **Comparison 20b. Place of Disposition (Nancametery, crematory or of carnetery, crematory or of comparison 20b. Place of Disposition (Nancametery, crematory or of carnetery, crematory or of comparison 20b. Place of Disposition (Nancametery, crematory or of carnetery)	other placa)	1	loc. Location - Cit						
ortant: Injury	4 Donation 5 Other (Specify) Arbutus Mem. Pk. Cem. 10-16-2000 A									
Department of Health Important: If Itam 27 any Injury or other to price.	21. Signature of Funerai Service Licensea 22. Name and Address of Facility WM.C. March FH 1101 E. North									
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heer failure. List only one ceuse on aech line.	le of dying, such as cardiac	or respiratory arra	st,	Approximate Interval Betwee Onset and Deal					
attending physician and I for use as the burial-transit cian/Medical Examiner	Due to (or as a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): HYPERTENSION Dua to (or as a consequence of):	ACCIDENT								
been signed by the attendin should be detached for use leted by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying of	cause given in Part I.	23b. Did tobacco uss contribute to the cause of o							
igned by be detail		During the last of	1 Y	s 2 1 No 3	☐ Probably 4☐ Uni					
sate hes been sign page 2 should by Completed b			24a. Was ar perform		24b. Were autopsy findi available prior to completion of caus of death?					
s certificate has birector, page 2 s			1□ Ye	s 2 No	1 ☐ Yes 2 ☐ No					
s certificate he director, page To Be Com	25. Was case referred to medical examiner?		th (Check only one	9)						
O	1 Yes 2 No Hospitel: Nanpatiant 2 ER/Outpatient 3 DC		ome 5 Reside							
After funen fon:	1 and the state of	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred						
within 24 hours after deeth. To the Funeral Director: Affer to completely filled in by the funeral Medical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, fectory building, etc. (Specify)			ion (Street and Number or Rural Route Number, or Town, State)						
within 24 hours after deem. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred on the basis of exemination and/or investigation, and manner steted.	at the time, date and place, in my opinion, death occur	and due to the ce red at the time, da	ouse(s) end menn ate and place, and	er as stated. I due to the cause(s)					
To the		c. License number	29	d. Date signed (Month, Day, Year)					
	NK Caba M.D P	-14184	0	CT. 11	: 2000					
	NKA-6-	. , - ,								
6	30. Name and address of person who completed causa of death (Item 23a) (Type, Print) VI3AY K GAGA RESIDENT, GOOD SAMAN		TAL; BI	ALTIMOR	16; MD					



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth OCTOBER 3 2000 ar **Physician** 6:30 AM ROGER F. HAMBY /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Genesis Cromwell Center Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Deta of Birth (Month, Dey, Year) **Funeral** Months Days 65 Director 577-44-7457 Apr 13, 1935 DC Usual Rasidence of Dacedent 10c. City, Town or Location permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiena.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic avent, the Medical Examples must be notified at page. 10a. State 10b. County 10d. Inside City Limits MD Director Baltimore Baltimore 1 Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8710 Emge Road 21234 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, 11. Maritel Status Black, Whita, atc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: white P 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) sales retail 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Ethel G. Johnson Jesse L. Hamby 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Clara Hamby/spouse 1000 E. Jopppa Rd # 212 Towson, MD 21286 20b. Pteca of Disposition (Neme of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stete 4 ☑ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Licensee.
Ropald S. Wade Director Millell Baltimore, MD 21201 23a. Pert Entar the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrast, shock or heart failure. List only one cause on each line. Approximata tntervat Between Onset and Death Physician Immediate Ceuse (Finet disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner attending physicien end for use as the burial-transit the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that inflieted events resulting in death) Lest Due to (or es e consequence of): Dementier Dua to (or as a consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the 1 □ Yee 2 □ No 3 □ Probably Unknown mession þ 24b. Were eutopsy findings eveileble prior to completion of causa of deeth? Be Completed 24e. Wes en eutopsy performed? page 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Menner of Death 1 Neturet 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred or Attending 5 Pending invastigation death. 1 ☐ Yas 2 ☐ No 2 Accident d in by tha 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide

6 ☐ Could not be **4** ☐ Homicide

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Data signed (Month, Day, Year)

29b. Signatura and title of certifian

29a. Certifier

054518

29c. Licensa number

10-10-00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

mund

pattimne MD 21214 MANTHA MAYMUNIM Northern Parkway 32. Registrer's Signature

State Registrar

DHMH 16 Rev 6/95

Saltimore, Maryland 21215-0020

68760

Box

P.O.

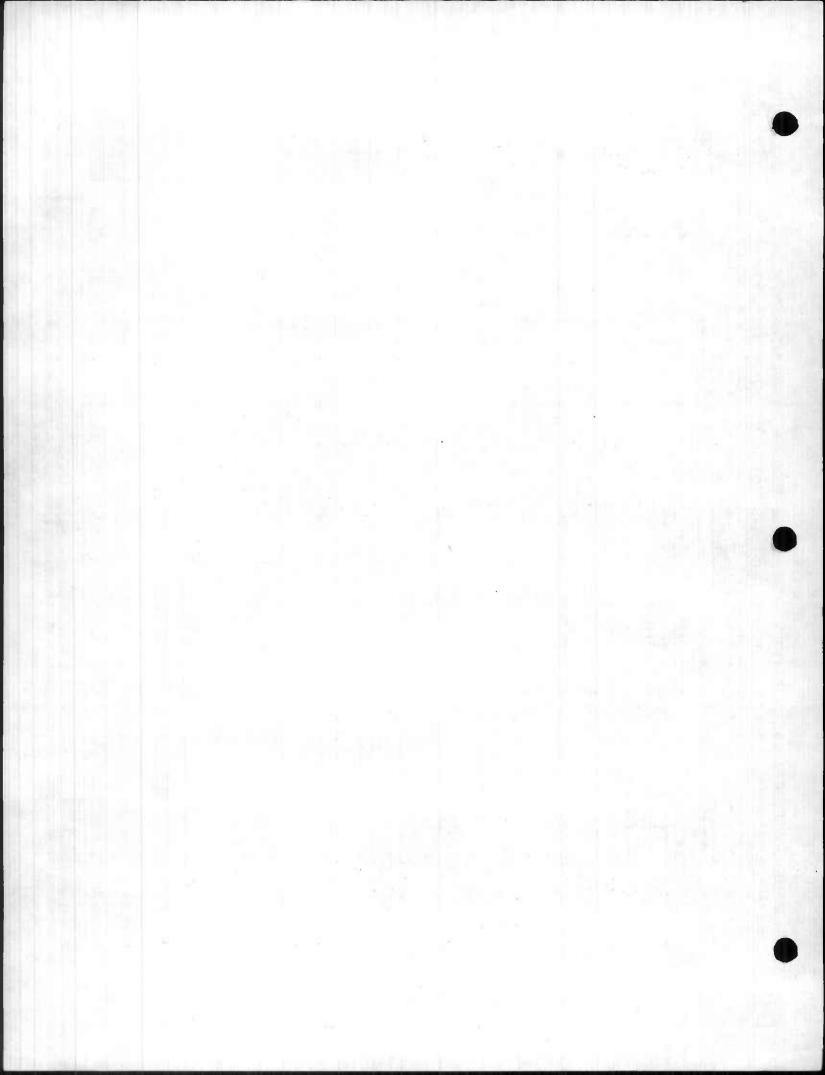
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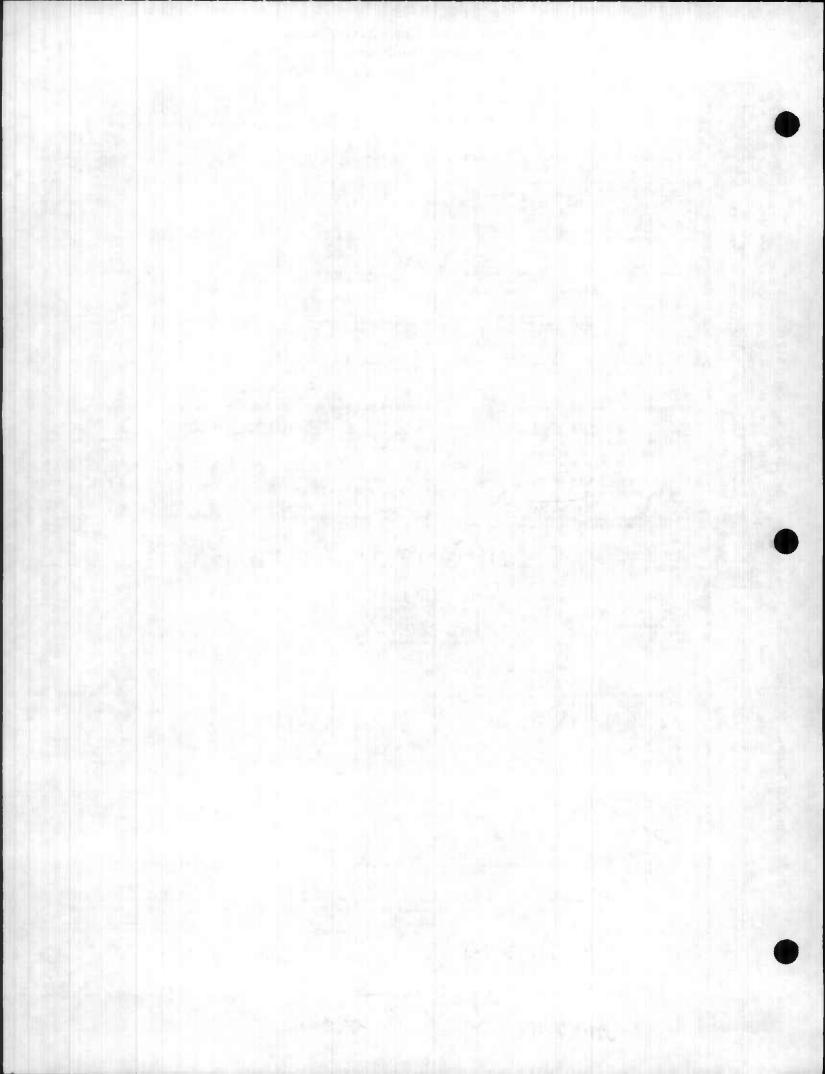
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To the Hospital within 24 hours a To the Funeral Completely filled Hospital



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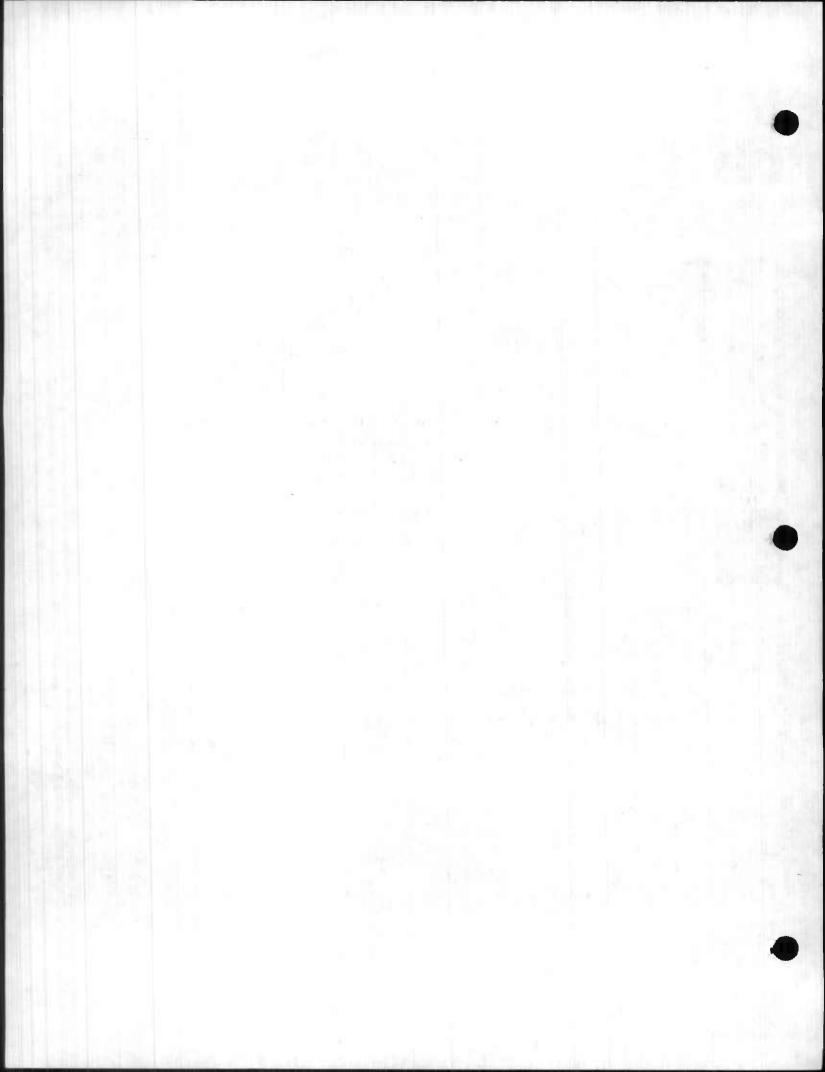
Certificate of	Death	Reg. N	lo.	
		2. Date of Death	New Year	3. Time of Death
HARTWELL	SR.			8:00 AM
	4b. City, Town, or Lo	cation of Death	c. County of Deeth	
LHOUN STREET	BALTI	MORE	N	A
Months Davs		8. Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign
69 Yrs.		JUNE 20,	1931 Sou	TI+ CAROLINI
10c City Town or Location				10d. tnside City Limits
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	ban, Mexican, Puerto	Rican, etc.)	Black, White,	
1 ☐ Yes 2 No	Specify:		Specify:	nav
16a Decedent's Usual Occi	unation	16b	Kind of Business/In	dustry
(Give kind of work done	e during most of works red)	ing	THE ST DESIGNATION OF THE PARTY	
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100/00/100		(First, Middle, Maide	en Sumame)	
TADTINE! 1	FIIZA	BETH	M	OULTRIE
	et and Number or Ruri	al Route Number, City		
11FE 22134)	SARAT	OGA ST	BAITA	MD - 2 122:
20b. Place of Disposition (Name of				
N.		1.12 12 13	ALTIMOT	MADILLAND
22. Name and Addr	ress of Facility	0-12-00 0	ALTHORE	MALYZANIE
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2140 N	, FULTON	JAVE., B	ALTIHORE	140.21211 Approximate
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Due to (or as a consequence or).				
out not resulting in the underlying cause of	riven in Part I	23h Did tohace	co use contribute t	to the cause of death?
Slo T	110			
OP TI	31 Therep	W. L.		
		24a. Was en eu		ere autopsy findings
		periorined	C	ompletion of cause
		1□ Yes	2 DNo 1	☐Yes 2☐No
	26 Place of Dogs			E 100 EE 110
ant 20 EB/Outpotiont 20 DOA 0	Wher:		6 DOther (Spec	(64)
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jury - At home, farm, street, factory, office	0			ral Route Number,
ic. (Specify)		City or Town, Sta	ate)	
of my knowledge, deeth occurred at the	time, date and plece,	end due to the ceuse	(s) end menner es	steted.
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29c. Licer	nse number	29d. [Date signed (Month	, Day, Year)
W) Dr	107786	M	toberin	th 2000
doests (from 22a) (Time Polyti	00100		1000	1000
GARNOUM)	TO 1.17	PKH. RIVI	1 ROTT	MD
rar's Signature	100 001	DI. DIM	7. DIVCI	1,451730
howar B to	n. i			
till a sit of the sit	HARTWELL Thou STREET Ige (In yrs. last birthday) If Under 1 Yea Months Day. Of Yrs. 10c. City, Town or Location BALT 10f. Zip Code OUN STREET 10f. Zip Code If Yes, specify Cu 10f. Zip Code If Yes, specify Cu 10f. Zip Code If Yes, specify Cu 10f. Zip Code If Yes, specify Cu 10f. Zip Code If Yes, specify Cu 10f. Zip Code 10f	Ab. City, Town, or Localized (In yrs. last birtholay) of the United Street (In yrs. last birtholay) of Yrs. In Months (In yrs. last birtholay) of Yrs. Months (In yrs.	HARTWELL SR. CTORES THOUSTREET BALTINGRE Ge (in yrs. lear birthday) Worth Days Hours Min. B. Date of Brith Veg. 1945. Was Decedent of Hispanic Origin? (Specify Yes or Not 1974) Worth Days Hours Min. B. Date of Brith Veg. 1945. Was Decedent of Hispanic Origin? (Specify Yes or Not 1974) Worth Days Work doine during most of working life brith of work doine during most of working life. Do NOT use retired CONSTRUCTION WORKER FOR Date of Days Worth Days Hours Name (First, Middle, Maid HARTWELL SPECIAL	HARTWELL SR. CTORED Day Variety Complete Day Street Control of Death Ac Country of Dea



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State of Maryland / Department of Health and Mental Hygiene 11 32372

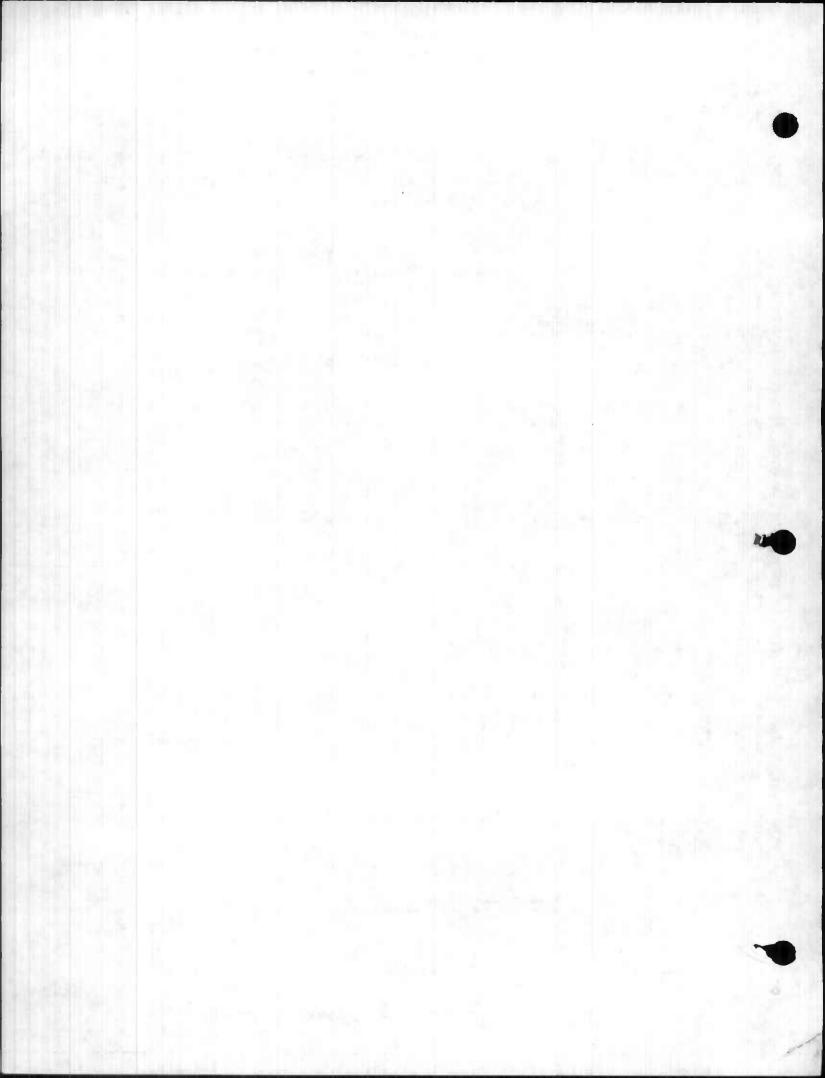
		C	ertificate of Deat	h R	leg. No.	16016			
Physiciar /Medica	1. Decedent's Name (First, Middle, Last) MILDRED	JOWARD		2. Dete of Dea Month Octobe	th Dey Yeer	3. Time of Death			
Examine	4n English Name // not institution sive street			Town, or Location of Death	4c. County of Death				
Funeral Director	5. Social Security Number 6. Sex 220 18 7700	7. Age (fn yrs. last birthd	Months Devs Hours	er 24 Hrs. 8. Dete of Birth (Month, Dey Oct. 18		nplace (State or Foreign untry) aryland			
Meryland a-f show	10a. Stete 10b. County		10d. Inside City Limits 11☑ Yes 2 □ No						
effer death with the Merylan or Name 23s or 28s-f show refree must be notified at	10a. Street and Number 1429 Woodall Street		10g. Citizen of What Cor	untry?					
OUZU hours after death with the Meryland tural; or items 23s or 28s-f show al Examiner must be notified at	3 ☐ Widowed 4 ☑ Divorced Y	as Decedent Ever in U.S. med Forces? Yes 2M No Yes, Give ear or Detes:	3. Was Decedent of Hispanic (If Yes, specify Cuban, Mexic 1 ☐ Yes 2 ☒ No Speci						
od within 72 hours at ygiene. The Medical Exam it, the Medical Exam	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12)	pleted) (G lift pliege (1-4or 5+)	cedent's Usuel Occupetion ive kind of work done during m e. DO NOT use retired)		16b. Kind of Business/I				
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yland buid be fil Mentel H arked out	17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmame) Lead In Father's Neme (First, Middle, Maiden Surmame) Lead In Father's Neme (First, Middle, Maiden Surmame) Lead In Father's Neme (First, Middle, Maiden Surmame)								
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Baltimore, Penes 1 s Department of He De	20a. Method of Disposition 1 X Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	rel from State cemetery,	sposition (Neme of cremetory or other plece) ill Cemetery	10/9/00	20c. Location - City or T Baltimore,				
Ball permit	21. Signifure of Funeral Service Licensee		22. Neme end Address of Fac 4001 Ritchie H	Gonce F	uneral Home				
Physician /Medical Examiner	resulting in deeth)	is thet ceused the deeth. Do not use on each line. Due to (or es e cor	Arrythmic		est,	Approximate Interval Between Onset and Deeth			
box ox/ou, leeth certificate be executed attending physician and if or use es the burial-transit	Cause (Disease or Injury that intilleded events are sulting in deeth) Lest Due to (or es a consequence of):								
at the death d by the atter	Part II. Other significant conditions contribut	Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Congestive Heart Failure							
law requires the second					med?	Were eutopsy findings syallable prior to completion of ceuse of death?			
VITAL MCI				1 🗆 Y	es 2 No	I□Yes 2XNo			
Slen: Striffic sctor,	25. Was case referred to medical examiner?			ace of Death (Check only o	ne)				
는 사람들 H	1 Yes 2 No Hospit 27. Menner of Deeth 1 Natural 5 Pending 2 Accident Investigation	el: 12 Inpatient 2 I ER/Outpa e. Dete of Injury (Month, Dey Year) 28b. Tim Inju	e of 28c. Injury et		lence 6 □Other (Spectow injury occurred	city)			
DIVISION C bal or Attending P is after death. al Director: After the ed in by the funers	3 Suicide 6 Could not be determined 28	e. Plece of Injury - At home, farm building, etc. (Specify)	street, lectory, office	28f. Location (S City or Tow	Street end Number or Ru m, Stete)	iral Route Number,			
To the Hospital within 24 hours a To the Funeral D completely filled		: To the best of my knowledge, don't the basis of examination end/ond menner stated.							
To the comp	29b. Signature end title of certifier								
6	30. Name and address of person who comple	21, Resident p	pe. Print) hysician at t	tuper Hapit	al center, &	Saltimore, 10-21225.			
State Registrar	OOT 1 3 7000	32. Regisfar's Signeture	D Looks						



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State of Maryland / Department of Health and Mental Hygiene 3 2 3 7 3

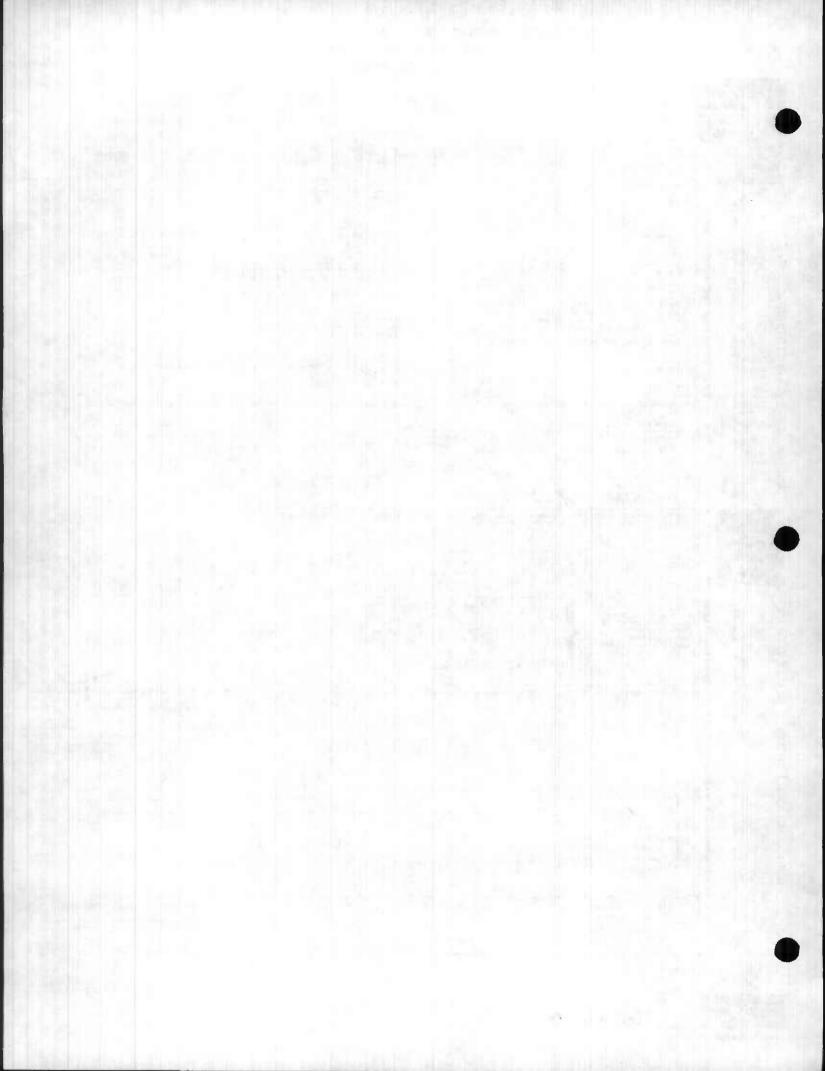
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	Physician	Joan	K. Hal	1					Month OCTOBE	R 12	2000	13	06	
	/Medical	4e Fecility Neme (If not institution, giv				- 4	b. City, To	wn, or Lo	ocation of Deeth	4c. County				
e di	Examiner	Union Memoria					Balt				/A			
-	-	Social Security Number 6. 5	-	rs. last birthday	If Under	1 Year	If Under		Date of Birth		0 D:4b-	leca /Stat	e or Foreign	
Г	Funeral Director	217-50-0234	10 M 25xF 53		Months	Deys	Hours	Min.	April	23, 19	47 M	aryl	e or Foreign and	
	pu *	Usuel Residence of Decedent 10e. Stete 10b. County			1	Od Ineida	City Limits							
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	oct of oct	Maryland N/A		Baltim										
	vith the Ma t or 28s-f a be notther	10e. Street and Number 10f. Zip Code								Og. Citizen of \	Whet Coun	itry?		
	r heme 23a direc munt Funeral	2808 Huntingdon Avenue 21211								USA				
	er de	11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Sp. If Yes, specify Cuben, Mexican, Puerto							ecify Yes or No- Rican, etc.)		e - Americ ck, White,			
5-0020	by	1 ☐ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Yeer or Detes:		1□ Yes	¥Ękno	Specify:			Specify	Whi	te		
15-0	c * a -	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	dant's Usua kind of wo DO NOT us	rk done i	durina mosi	t of work	ing	16b. Kind of B	usinass/Ind	dustry		
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7	should be end Mentel a marked o aumatic ev	19a. Informent's Name/Reletionship (Tune Print)	10b Maili	ing Address	Street			al Route Number			Code)		
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Baltimore,	-155	20e. Method of Disposition		Plece of Disponentery, cre	osition (Nar	ne of	ce) .		Date	20c. Location	City or To	wn, Stete		
Ĕ		1 Buriel 2XX remetion 3 4 Donetion 5 Other (Specif	(y) Barrow State	alto-W	ashi	ngt	emato on	ory 1	0/13/0	0 Lau	rel	Mar	brelv	
alti	permit. Pag Department Important: Il any Injury o	21. Signature of Funerel Service Lice		2	2. Name ar	d Addra	ss of Fecilit	v						
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		23a. Pert1. Film the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.											nd nete	
	Physician	shock, heert failure. List only	one cause on each line.									Onset er	Between nd Death	
d	/Medical	Immediate Cause (Finel		1	chai	. ()	10-				i	11. ~	an Hac	
	Examiner	Immediate Cause (Finel disease or condition resulting in death) e. renal obstruction										6 1110	onths	
	6	Due to (or es e consequence of): n metastatic colon cancer										100	onths	
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68760,	entificate be ling physicie is es the bu	resulting in death) Lest	D00 (C	(or es e conse	querica orj.									
Box	nat the death certificate be asscuted dby the attending physician and letached for use as the bunal-transit Physician/Medical Examir		d					П						
	the short hed I	Pert II. Other significant conditions of	contributing to death but not	resulting In the I	underlying o	ause giv	en in Pert I		23b. Did tobacco use contribute to the cause of death?					
, P.O			5851								3 Pro	bably 4	Unknown	
Sp	w requires that been signed I should be det								24a. Wes e	n eutopsy			sy findings	
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5	hya his	1 Yes 2 No		□ ER/Outpetie			4 🗀 M	irsing Ho	me 5 Resid			(y)		
-	ding P. Th.: After t	27. Manner of Deeth 1. SNaturel 5 □ Pending	28e. Dete of Injury (Month, Day Year	28b. Time of Injury		28c. Injur Wor			28d. Describe h	ow injury occur	rred			
Sio	Attending in death. •ctor: After by the fune iffication	2 ☐ Accident investigatio			М		Yes 2	No						
Division of Vital Records,	be or Attending P is after death. In Director: After the in by the funerated in by the funerated in certification:	3 Suicide 6 Could not b 4 Homicida datarmined	28a. Placa of Injury - A building, atc. (Spa	t homa, farm, si acify)	traet, factor	y, office			28f. Location (S City or Tow	treet and Numi n, Stata)	ber or Rur	al Route N	lumber,	
		29a. Cartifier 1 Certifying Ph	nysician: To the best of my l	knowledga, daal	th occurred	at tha tir	na, data an	d place,	and dua to the c	ause(s) and m	annar as s	statad.		
	n 24 hound in 24 h	(Check only 2 Medical Exar	niner: On the basis of examend menner steted.	inetion end/or in	nvestigation	, In my o	pinion, dea	ith occur	red et tha tima, d	lata and place,	end due te	o the caus	ie(s)	
	Withir Comp	29b. Signeture end title of cardiller 29c. Licensa number								9d. Date signe	ed (Month,	Day, Yea	r)	
) WY W	7012		A	Tó	1438	391	46	101	2/5	20		
		30. Neme end eddress of person who	completed cause of deeth (tem 23e) (Type	. Print)			7111			•			
6		KRISTIN ROBER	TS MO 201	E. UNI	VERS	TTY	PILL	Y	BALTIM	ORE N	MO	212	218	
	State	31. Dete filed (Month, Day, Year)	32. Registrar's Si	gneture	4	1.	. , ,							
	Registrar	OCT 13	7000 1 244	was ,	hed)	400	exs							



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State of Maryland / Department of Health and Mental Hygiene 00 32374

				Ce	rtificate o	f Deati	ר		Reg. No.			
Physician /Medical	Decedent's Name (First, Midd Marvin	le, Last)		Ing	gram	346		2. Date of Dec Month Octobe	Day	Year 000	3. Time of Death 10:15 am	
Examiner	4a Facility Name (If not institution North Arunde)				Hins.			ocation of Death	4c. Count			
Funeral Director	5. Social Security Number 226-28-2886	6. Sex 1√2 M 2□ F	7. Age (In yrs. 76	last birthday) Yrs.	If Under 1 Yea	ar If Unde	or 24 Hrs.	8. Date of Birt (Month, Da Oct. 6	h Year)	9. Birthp	place (State or Foreigntry)	
	Usual Residence of Decedent											
when 'z nous are cean win the maryand then "natural", or items 23s or 28s-1 show the Medical Exercises must be notified at empleted by Funeral Director	MD Anne	Arundel	200 100	y, Town or Lo						1	0d. Inside City Limi	
- 128 P	10e. Street and Number	et and Number 10f. Zip Code								What Cour	ntry?	
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r tems 23 instrument	11. Marital Status	L16 Indian Landing 21108 arital Status 12. Was Decedent Ever In U.S. 13. Was Decedent of Hispanic Origin? (Spe								ce - Americ	an Indian,	
5 M	1 ☐ Never Married 20XMar	Armed Forces? If Yes, specify Cuban, Mexican, Puerto							Ble	ck, White,	etc.	
by i	3 Widowed 4 Divorced	If Yes G	ive		1□Yes 2XIN	o Specif	y:		Specia	y: Whi	White	
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ygiene. 4. De Medical Completed	(Specify only highe	it's Educetion st grade completed,)	(Give	kind of work don	ne during me	ost of work	king	TOD. KING OF E	03111033/1111	oustry	
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	12			Mecha	IIIC	40.14.5		(E) h () ()	Groc			
B Sott	17. Father's Name (First, Middle,							ne (First, Middle,		ne)		
Mental arked o arke eve To Be	Meshaeh Ingram	1	Full			C.	Lemen	ce Cart	er			
PES	19a. Informent's Name/Reletions	ship (Type, Print)		19b. Maili	ng Address (Stre	et and Num	ber or Ru	ral Route Numbe	er, City or Town	, Stete, Zip	Code)	
	Lilliam M. Inc	ram (Wife	e)	1116	Indian	Land	ing.	Millers	ville.	MD 21	108	
freeith item 27 i other tre	20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of			Date	20c. Location			
P F P	XXBurial 2 Cremation		State		matory or other p			10/13				
ortmen ortant: injury	4 Donation 5 Other (5		Our		of the			2000	Miller	svil1	e, MD	
Department of I	21. Signature of Füheuti Segrice	Licengee //	1	2:	2. Name end Add Hardes	ress of Fac	ility nera1	Home . P	. A .			
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	23a. Part1. Enter the disease shock, or heart failure. List	complications that	caused the deat	h. Do not en							Approximate Interval Between	
nding physician and use as the bunal-transit	Cause Disease or injury that initiated events Due to (or as a consequence of):) day	
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page Com								10	Yes 20 No	1 {	□Yea 2 No	
certificata rector, pag												
is cert direct	examiner?	Hospital:	Inpatient 2	ER/Outpatle	nt 3 DOA	Wher:		ome 5 Resi		her (Specif	(v)	
within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (27. Manner of Death Natural 5 Pendii 2 Accident investi 3 Suicide 6 Could 4 Homicide determined 29e. Certifier Certifyli (Check only one) 2 Medical	28a. Date (Moi gation not be nined 28e. Plac buik 28e. Plac buik 28e. Plac buik 28e. not be and mai	e of Injury nth, Day Year) te of Injury - At hi ding, etc. (Specification)	28b. Time of Injury ome, farm, st	of 28c. In V 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ijury at vork? Yes 2	□ No	28f. Location (City or Total), end due to the rred at the time,	Street and Num wn, State) cause(s) and n dete end plece	nber or Rura	al Route Number, stated. o the cause(s)	
No To	29b. Signature and title of certifie	()	Not	0	29c. Lice	nse numbe	-	7)	29d. Date sign	ea (Monin,	Oay, rear)	
1	1 Cm	70)	1221	1	1	15)	15		Octo	790	7,1000	
5	30 Name and address of person	who completed ceu	Lucy (n 23a) (Type,	Print)	50	(air	High	ray (Hab	world U	
State Registrar	31. Date filed (Month, Day, Year,	2000 32.	Registrar's Signa	ture	Span	4		-	130		1, 1	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** OCTOBER heams Planche 10, 2000 3:00 PM /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Yaar | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 M 2 F 0/3 213-03-3688 Yrs. December 18, 1906 Mary/And Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Directo alle Macyland 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 6 the Medical Examiner must be 8820 Blud. 238 U.S.A. 21234 Funeral Was Decedant Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - Amarican Indian, Black, White, etc. Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) "natural", or items 11. Marital Status 1 ☐ Nevar Marriad 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: p 3 Widowed 4 □ Divorced Shite Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 88 should be true Mental is marked Albert E. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If Hem 27 is 1 Enaron Miller- Daughter 20b. Place of Disposition (Name of cometery, crematory or other place)

Even's Funcial Chapel
Belau P.A. Prikuille Court mis 21234 Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State Idialoo Belmi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Euros Frech Charles Bond mo alazy Prokulle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) PNEUMONIA /Medical 4 DAYS **Examiner** Dua to (or as a consequence of): Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last tata has been signed by the attending physicien end page 2 should be detached for use as the burial-tran Due to (or as a consequenca of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy SIDEROBLASTIC ANEMIA performed? 1 Yes 2 No 1 🗆 Yes After this certificata pepital or Attending Physician: Thours after death.
Inerel Director: After this certificat
y filled in by the funeral director, p Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) To Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 Yes 2 No

P.O. Box 68760. Division of Vital Records.

To the Hospital of within 24 hours a To the Funeral D completely filled

DHMH 16 Rev 6/95

BEATRIZ P. DIZON, 31. Date filed (Month, Dey, Year) State Registrar

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signatura and title of certifiar

3 2000

6 ☐ Could not be

M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. Licansa number D0016492

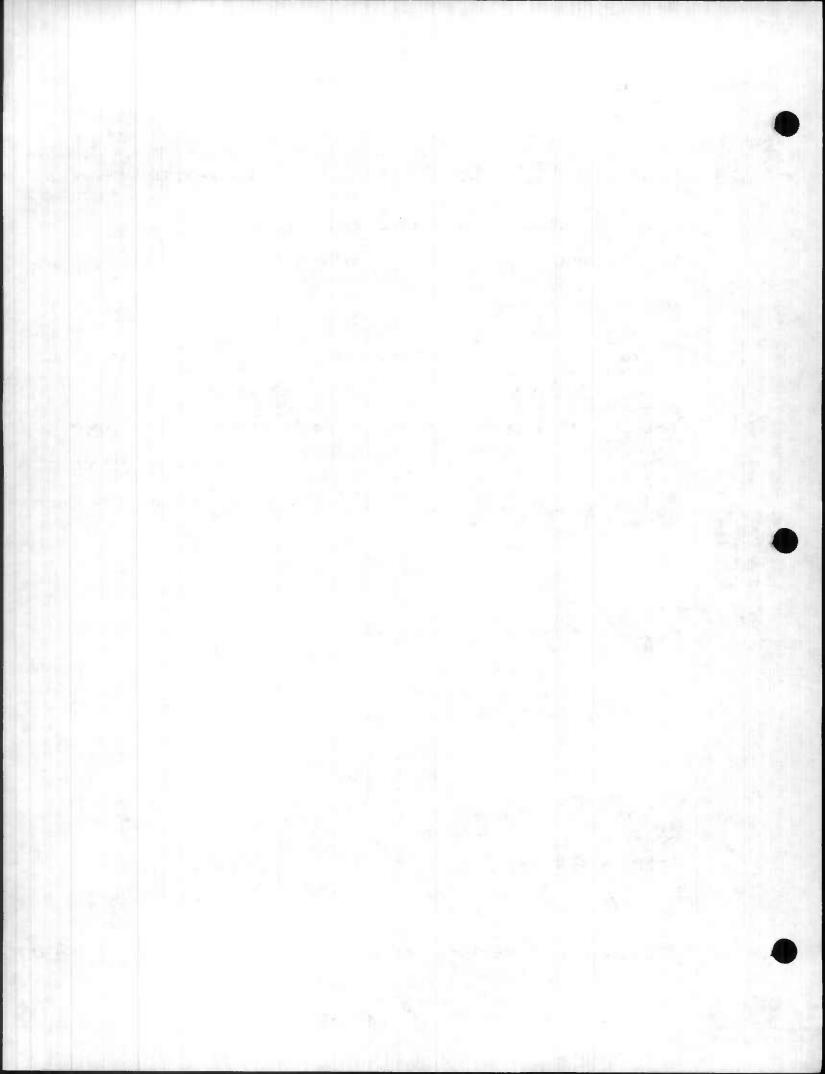
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

October

29d. Date signed (Month, Dey, Year)

10,2000

28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October Day Year **Physician** 5.55pm Obert 12 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Rosedale Franklin Square Hospital Center If Undar 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign Country)

Mary and **Funeral** 86 Yrs. Months Days 1 M 2□ F 216-10-6398 Director 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show must be notified at 1 ☐ Yes 2 No by Funeral Director LHMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ð 2804 21234 Rema 23a 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: WW... 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 ☐ Nevar Married 2 ☐ Married Maryland 21215-0020 ò 1 ☐ Yas 2 No Specify: While Specify: 3 Widowed 4 □ Divorced 'natural' Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) Rober 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 ament of Health an Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lices 22. Name and Address of Facility varis Fact 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such) as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) a 1ScHemic CardiomyPathy Examiner Due to (or as a consequence of): Physician/Medical Examiner multi-organ System Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhiated events resulting in death) Last Due to (or as a consequence of): Box 68760 acute Renal failure 8 a Hepatic failure 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Certification: To Be Completed completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1. Natural 1 Yes 2 No 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide b within 24 hours Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. edical 29a. Certifier (Check only one) \$ 29c. License numbar 29d. Date signed (Month, Day, Year) 29b. Signature and this of certifiq RD203265

State Registrar

DHMH 16 Rev 6/95

9000 Franklin Square Drive Baltimore MD 21237

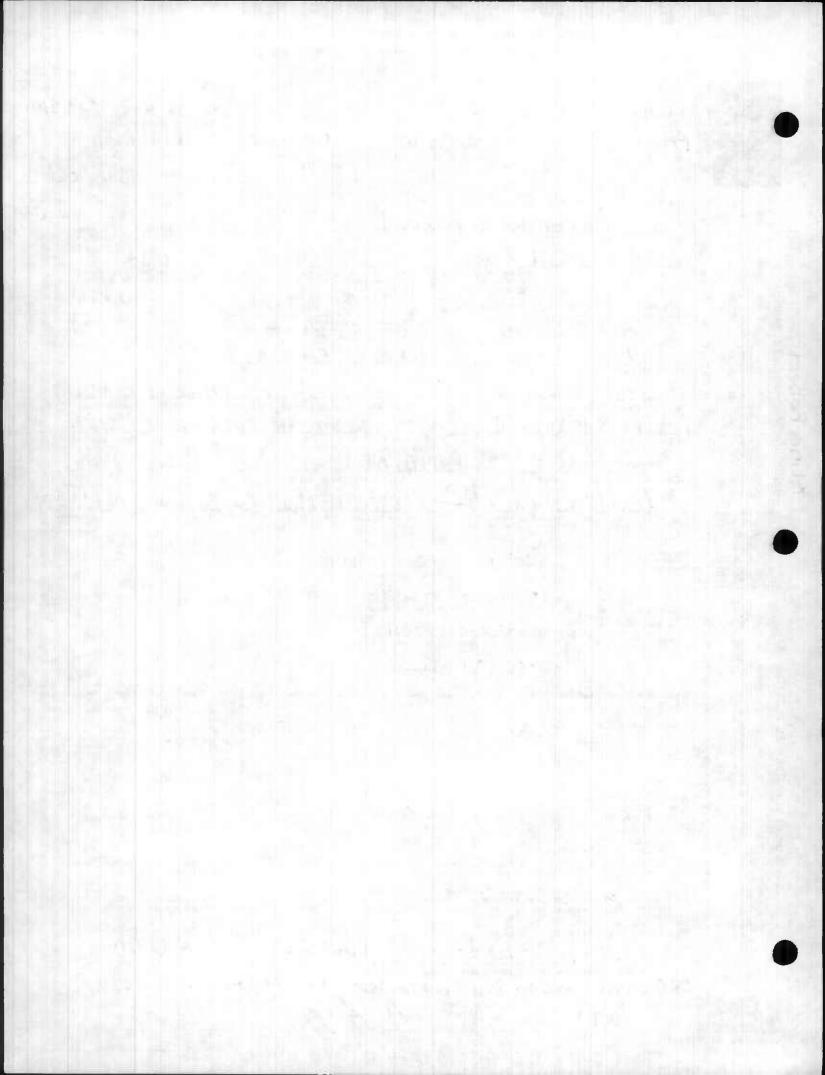
30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

32. Registrar's Signature

DR GIUSEPPE Esposito

OCT 13

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey **Physician** L. KAMMER 6:05 AM Oct. 12 SANDRA 2000 /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not Institution, give street end number) 4c. County of Deeth Examiner BALTIMORE
If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Year) NA LINWOOD 2702 If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** 1 M 2 F Months Deys Yrs 216-84-2575 39 Director Ma Usuel Residence of Decedent 10a. Stelle 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Medical Examinar must be notified at 18Yes 2□ No Director Md BALTIMORE, 10e. Street and Number 10g. Citizen of What Country? AVE 21224 45/4 Funeral LINWOOD 2702 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Merital Stelus 1 ☐ Never Merried 2 ☑ Merried 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: WHITE by If Yes, Give Year or Detes 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ORK 12 OFFICE MANAGER 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if fem 27 is marked oth any injury or other traumatic even obtas. BRAMBLE GOSEPH LOUISE SEWELL 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO Md 21224 AV. 2702 LINWOOD BRIAN W. KAMMER 1 SPAUSE Baltimore. 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Slete 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) GREENMOUNT CREM. 100 BALTO FUNERAL HOME, CHTS. 21. Signeture of Fundral Service Licensee 22. Name end Address of Fecility HARTLEY MILLER Md 21234 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear/failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Liver tailure **Examiner** Due to (or es a consequenca ot): Metastotic Physician/Medical Examiner tsophogea Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Box 68760. Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco was contributs to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown þ of Vital Records. page 2 should be 24b. Were eutopsy tindings eveilable prior to completion of cause of death? 24a. Wes en autopsy performed? Be Completed 1□ Yes No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medicel 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes ZNO Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28c. injury at Work? 28d. Describe how injury occurred Division Neturel 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident tha 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 2 4 Homicide To the Hospital within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifie 29c. License number D16587

State Registrar

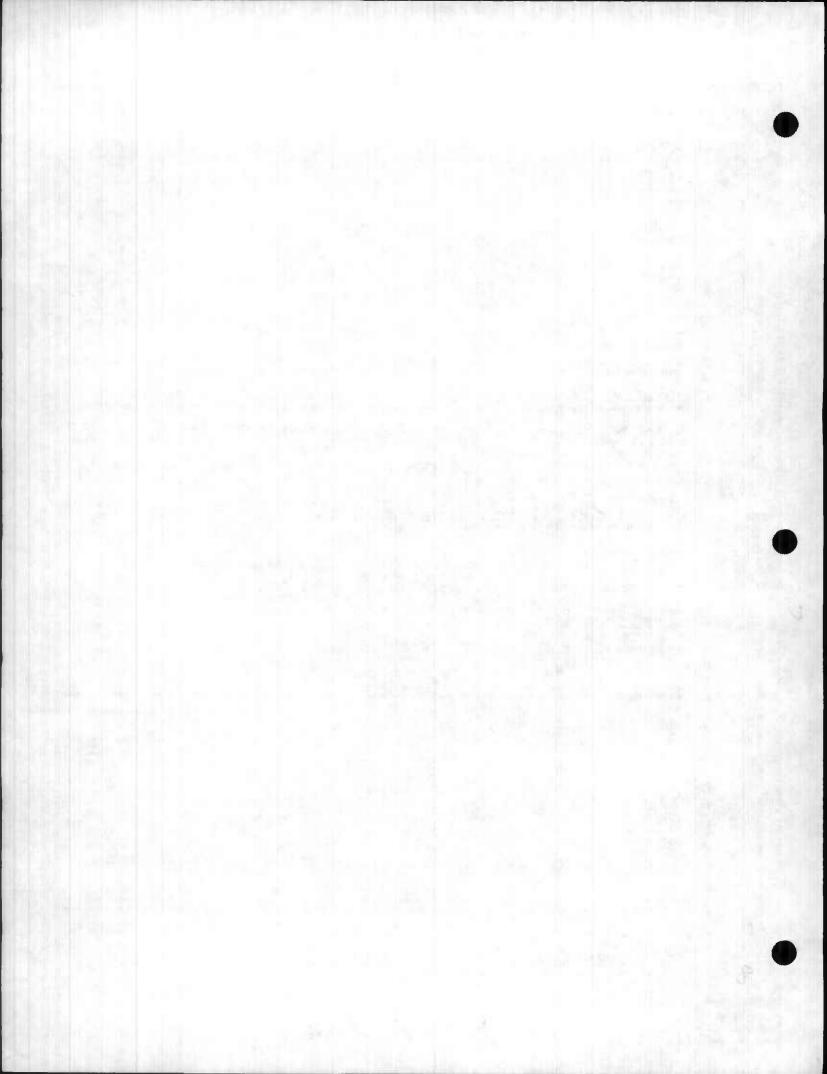
DHMH 16 Rev 6/95

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31. Dete tiled (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
Paul Chane, Ma 5601 Loch Rawn Blod, Ste 103, Baltinoni, M21239 32. Registrer's Signeture

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 3 7 8

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	or 284-1	10e. Street and Number 10f. Zip Coda									Whet Country?		
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215-0020	ur, or its Examina by Fu	1 Never Married 2(1 Yes 2					Specify:	ano Alcan, etc.)	Specify	ck, White, etc.	
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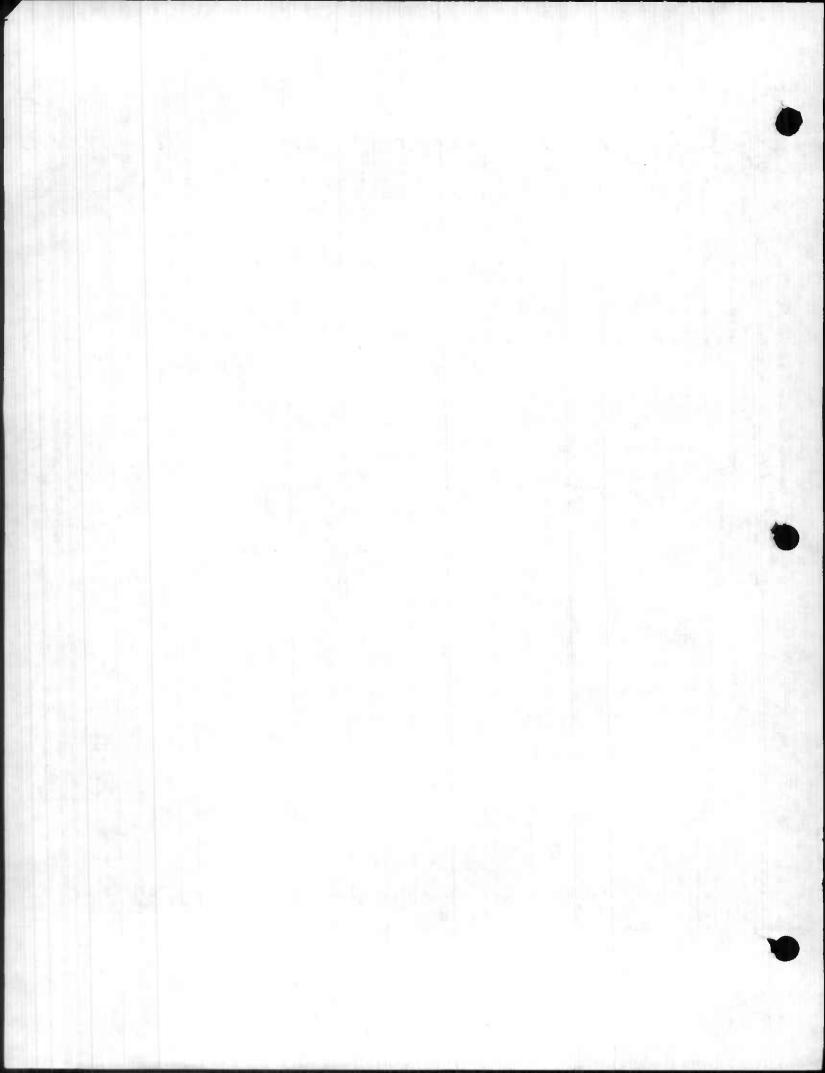
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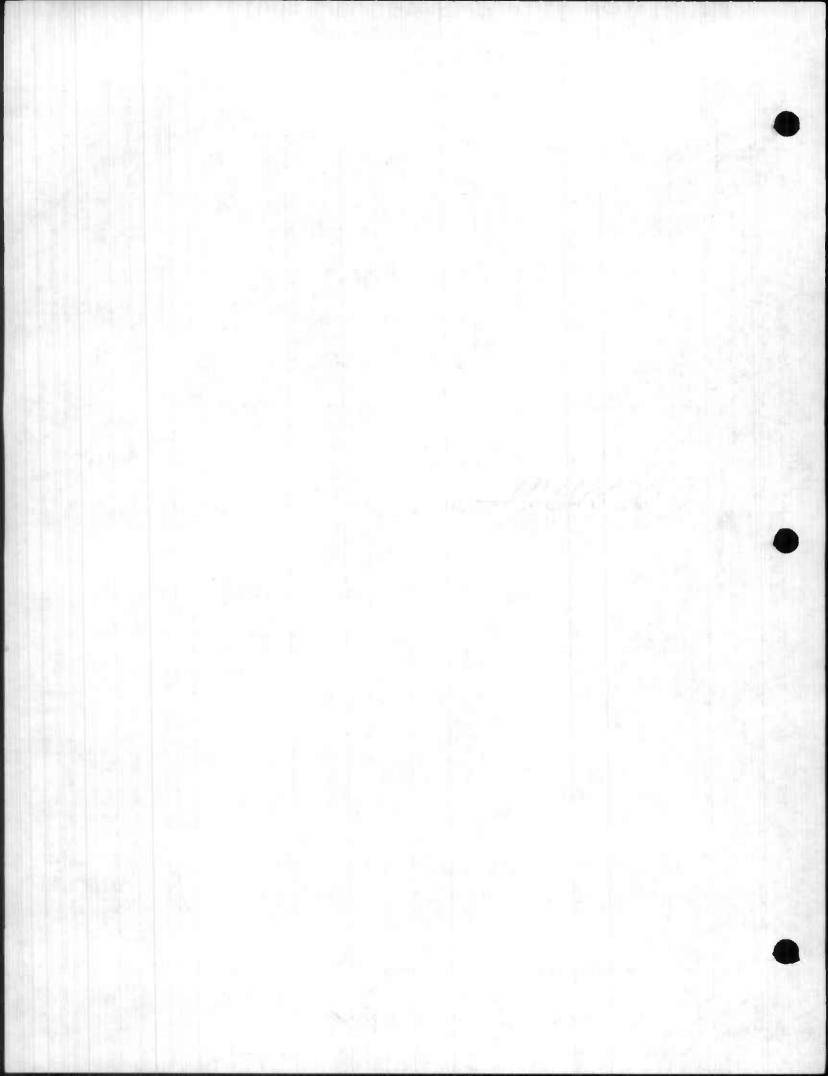
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State of Maryland / Department of Health and Mental Hygiene | |

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** 062 12,2000 october /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Nama (If not Institution, giva street and number) Examiner Middle River If Under 1 Year Birthplaca (Stata or Foreign Country) 5. Social Security Number 6 Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** 150 M 2D F Hours Min. Months Days 213-09-3224 96 March 22,1904 Director Maryland Usual Rasidence of Decedent the Marylend 10b. County 10c. City, Town or Location 10a Stata 10d. Insida City Limits mant be notified at 1 Yas 2 No Directo **Baltimore** Essex 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? Herns 23a or 21221 TISA 618 Eastern Avenue Funeral 72 hours after death 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒No If Yas, Give Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - American Indian, 11. Marital Status Black, White, atc 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yas 2 ☑ No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) then. Elamantary/Secondary (0-12) Collega (1-4or 5+) 8 Bethlehem Steel Foreman 18. Mother's Neme (First, Middla, Maidan Surnama) 17. Father's Nama (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If from Z7 is marked other any injury or other traumatic event pages. Be Theodore Letke Mary Fisher 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Dave Letke/Son 618 Eastern Avenue, Baltimore, MD 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 10/14/00 Baltimore, Maryland Holly Hill 21. Signatura of Funeral Servica Licensea 22. Nama and Address of Facility Connelly Funeral Home Of Essex 23a. Part1. Enter the disease, or complications that caused the peath. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List or you be cause on each line. 21221 Approximete Intarval Batween Onset and Death Physician Immediata Causa (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner The lew requires that the death certificate be executed been signed by the attending physicien end should be detached for use as the bunal-trensit Sequentially list conditions, if any, laading to immadiata causa. Enter Undarlying Ceuse (Diseasa or Injury thet initiated avants rasulting in death) Last Dua to (or as a consequence of): Box 68760. Due to (or as a consequence of): P.O. 1 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown landare Division of Vital Records. p 24b. Wara autopsy findings available prior to completion of cause of death? Completed 2 No 1 Yes 2 No 1 Yas this certificate apital or Attanding Physician: The hours after death.
ners! Director: After this certificate y filled in by the funeral director, pa Be 25. Was casa rafarred to medical examinar? 26. Placa of Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: Nursing Home 5 Residence 6 Othar (Specify) 1 Yas 2 No 2 27. Manner of Death 1 Neturel 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accidant 3 ☐ Suicida 6 Could not be determined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 ☐ Homicida within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar edical 29c. Licansa number 7-3829d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier M.D 10-12-2000 30. Name and address of person who complated causa of daath (Item 23a) (Type, Print) OSLVD . MD - 21221 709. BASTBRN WASERM. 2000 Segue Signatura State Registrar



	1. Decedent's Name (First, Middle, Last)	Reg. N 2. Dete of Death		3. Tima of Deet							
sician edical miner	Jose Martinez, M.D.	October	Dey Year Zoc								
eral	Franklin Square + OSPItal Center KOSE 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) Morths Deys Hours Min	n. (Month, Dey, Yea	Bal+	More or Fortunity)							
tor	219-40-4714 70 Yrs. Usual Residence of Decedent	Feb. 9, 19	30	Egypt							
	10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Lin							
Funeral Director	Md. Baltimore Parkville 10e. Street and Number 10f. Zip Code	10g. C	Citizen of Whet C	1 ☐ Yes 2 🛣							
rail	8810 Walther Blvd. 21234		USA								
by Fune	11. Maritel Stetus 12. Wes Decedent Ever In U.S. Armed Forces? 1 □ Never Merried 2 Married 2 Married	(Specify Yes or No- erto Ricen, etc.)	14. Race - Am Bleck, Wh Specify: Wh								
	15. Decedent's Education 16e. Decedent's Usual Occupation (Specify only highest grade completed) 16e. Do NOT use retired)	16b.	Kind of Business								
EO	Elementery/Secondary (0-12) College (1-4or 5+) 12 S+ Medical Doctor	Sel	lf emplo	yed							
Bec	Ď	eme (First, Middle, Maide									
2	Francisco Martinez		Kalpha								
	19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or I			Zip Code)							
	20a Method of Disposition 20b, Place of Disposition (Neme of	onium, Md. 2	Location - City o	r Town, Stete							
	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Cemetery, cremetory or other place) Dulaney Valley Memorial	10/12/00	Γimonium	Md							
	21. Signature of Funeral Service Licensus 22. Name end Address of Fecility Ruck Towson Fune:	ral Home, In	nc.	,							
	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi	son, Md. 212 iac or respiratory errest.	204	Approximete Interval Between							
	shock, or heart feilure. List only one cause on each line. Immediate Cause (Finel disease or condition The Chanial He More	nhase		Onset end Dea							
/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of):										
cian		ant Olds.		1							
y Physi	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.	1 Yes	23b. Did tobecco use contribute to ti								
9		24a. Wes an eu performed		. Were eutopsy find evailable prior to completion of caus of deeth?							
piete	<u> </u>										
Completer		1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No							
Be Completed by Physician/M	25. Was cese referred to medical examiner?	1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No							
To Be	25. Was cese referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing		6 □Other (Sp								
To Be	25. Was cese referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Peath (Check only one) Home 5 Residence	6 Other (Sp njury occurred	ecify)							
To Be	25. Was cese referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Street	6 Other (Spinjury occurred	ecify) Rural Route Number							
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To Be	25. Was cese referred to medical examiner? 1	Peath (Check only one) Home 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Street ce, end due to the ceuse curred at the time, date of	6 Other (Sp njury occurred	ecify) Rural Route Number as stated. ue to the cause(s)							



							Ce	rtificate	of	Death		Reg. No.		32382	
Physicia /Medic		1. Decedent's Name (First, Mic RUTH MILI		st)							2. Date of D Month OCTOBE	Day	Day Year 3. Time of 3:27		
Examin	_	4a Facility Name (If not institu									City, Town, or Location of Death 4c. County of Dea				
		Stella Maris		-				If Undar	Voor	Timonium			Baltim		
Funeral Director		5. Social Security Number 215-18-5769 Usual Residence of Decedent	6. S	ex □M 2⊠F	7. Aga	103	Yrs.		Days	Hours Min.	8. Date of B (Month, U Sept 2	lay, Year)	hplace (State or Foreign nuntry) MD		
and a		10a. State 10b. Cour	ity			10c. City,	Town or L	ocation				-		10d. Insida City Limits	
Marylar -f ehow	tor	MD Bal	timo	re			P	arktor	1					1 ☐ Yas 2X No	
r 286	Funeral Director	10e. Street and Number	-				-15-17	10f. Zlp (10f. Zlp Coda			10g. Citiz	an of What Co	ountry?	
h wit	0	2327 Mt. Carme	1 Ro	ad					2	21120			USA		
deat	ner	11. Marital Status		12. Was Dec		var in U,S.	13.	Was Dacede	ent of h	Hispanic Origin? (Sp an, Maxican, Puarto	pecify Yes or N	10-	4. Race - Ame Black, White		
urs e	þ	1 Never Married 2 M 3 Widowed 4 Divord		1 Tes If Yes, G Year or I	2X N	o		1 Yes 2					Specify: Wh		
72 ho	et e	15. Deced	ent's Ed	lucetion da complated	')		16a. Dece	dent's Usual	nt's Usual Occupation ind of work done during most of work O NOT use retired)			16b. Kin	d of Business/	Industry	
Men.	Be Completed	Elementary/Secondery (0-12	1	College		+)		nool t					3		
lled v her ti	8	17. Father's Name (First, Midd	lo Last)		-		SCI	1001 L	eac		e /First Middl		education Maiden Surmame)		
d d d d d d d d d d d d d d d d d d d	Be	Benjamin G. M:					18. Mother's Neme (First, Middle, Maiden Surma Cora Stockdale					omanie)			
Maryland d2 should be file h and Mental Hy 7 le marked othe treumatic event	To	19a. Informant's Name/Relation Benjamin Millo	nship (7	Type, Print)						t and Number or Ru	ral Route Num	ber, City or	Town, State, 2		
end ealth m 27		Benjamin Miller/nephew 2327 Mt. Carmel Road Parkton, MD 21120 20a. Method of Disposition (Neme of cemetery, crematory or other place) 20b. Place of Disposition (Neme of cemetery, crematory or other place)													
Page nant o		1 Burial 2 Cramation 4 Donation 5 Other			State	cen	netery, cre	matory or of	her pla	ace)	Date	200. 100	ation - City or	TOWN, State	
pemit. Pag Department Important: I any injury once.		21. Signature of Funaral Servi	Se Licen	Wade /	Dir	ctor		2. Name and State Baltin	Ana	ess of Facility atomy Boar		W. B	altimo	re Street	
		23a. Part1. Enter the disease shock, or heart failure.	or comp	olications that	caused	the death.						arrest,		Approximate Interval Between	
Physician	Ωď	STORY OF FIGURE 12 III OF 12	iot orny t	one cause on	04011111	0.								Onset and Deeth	
/ /Medical Examiner		Immediate Cause (Final disease or condition a CONGESTIVE HEART FAILURE													
- 11-12-12-12-12-12-12-12-12-12-12-12-12-1	_	resulting in deeth) Due to (or as a consequence of):													
po iii	al le														
be axecuted sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immadiata													
A Gia	la la	Cause (Disease or Injury	4	c											
death carlificete e attending physical for use as the	Physician/Medic	that initiated events per the property of the													
attending for usa	lan/			O						JOHN ST					
the day	yslc	Part II. Other significant cond	itione co	ontributing to	death bu	t not resulti	ing in the	underlying ce	usa gi	iven in Part I.	23b. Di	d tobacco u	ea contribute	to the causa of death	
											1[Yee 2	No 3□P	robably 4 Dunknov	
ne lew requires that has been signed be ga 2 should be date	Completed by										,	Wera autopsy findings available prior to completion of ceuse			
has b	Idu			, 5 A.								74		of death?	
	S											Yes 2	No	1 Yes 2 No	
ician: The	Be	25. Was cese referred to med exeminer?	cel	Hospitel:	and to				. 01	26. Piece of Dee			7		
E E =	5	1 ☐ Yes 2 📉 No 27. Menner of Deeth		11	Inpatier of Injur	-	R/Outpatie		^	4 LI Nursing Fi	ome 5 Re 28d. Describ			HOSPICE	
Affer funa	tlon	1 Netural 5 ☐ Pen	ding stigetion	28a. Date (Mo	nth, Day	Year)	fnjury	M	Bc. fnju Wo	ork?]Yes 2∐No		,,,,,,			
of Attending Physician: T is of Attending Physician: T is of detailed in the fundral director, py d in by the fundral director, py	Certification:	2 Accident investigation 3 Suicida 6 Could not be determined 28e. Place of Injury - At homa, farm, street building, etc. (Specify)							office		28f. Location City or 7	(Street and own, State)	Number or R	ural Route Number,	
To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A complately filled in by tha fi	edical Ce	(Check only 2 Medic		iner: On the I	basis of	axaminatio				ime, date and place opinion, daath occu					
the I	Med	20h Signature and title M cort	fior	and ma	nner stal	ted.		29c. License number			courred at the time, date and place, and due to tha cause(s) 29d. Date signad (Month, Day, Year)		th. Day. Year!		
5.¥ 5 8		29b. Signature(and title observirier							D43725 290. Date signal			0/6/	1 6 / d U		

State Registrar

DHMH 16 Rev 6/95

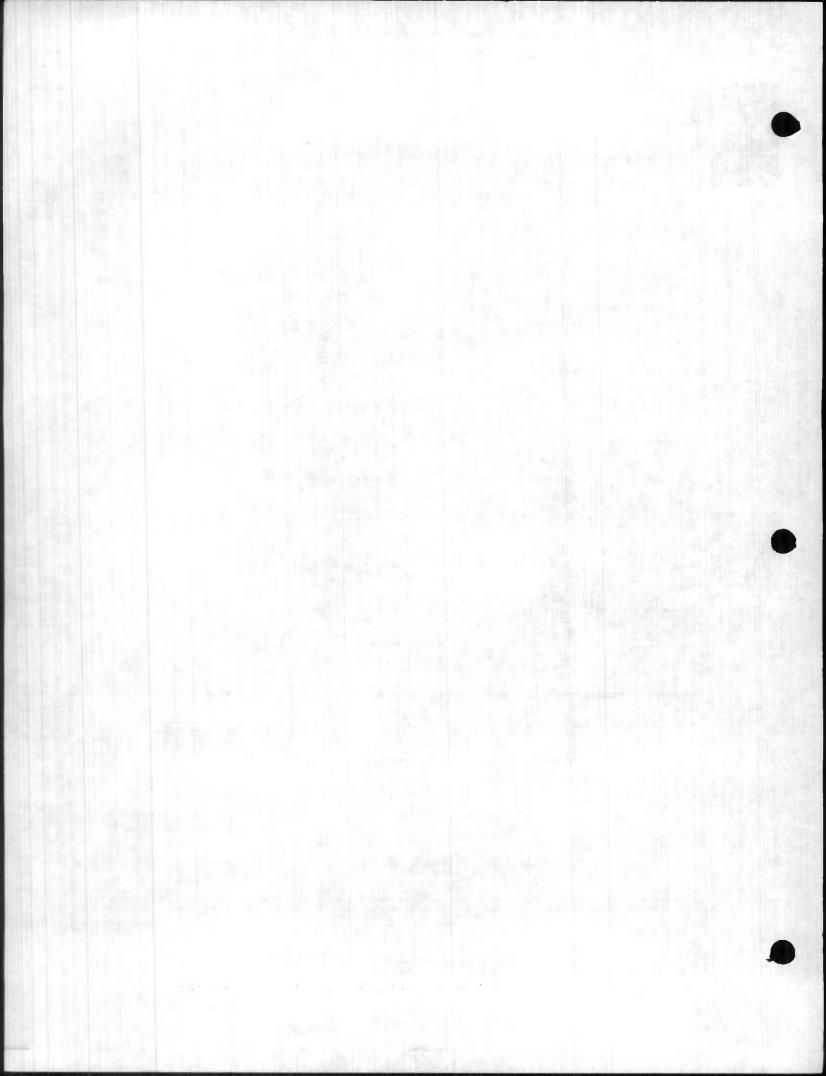
TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
OCT 1 3 2000
Server

DR. TARIQ_MAHMOOD



State of Maryland / Department of Health and Mental Hygiene (

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-	green)	0	0	0

72 hours after death

attending physician end for use as the burial-trensit The law requires that the death certificate be executed signed by the a hes After this certificate or Attanding Physician: funeral

Division of Vital Records, P.O. Box 68760,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** September 30, 2000 SALLY T. MOHR 7:00 PM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** FOREST GLEN NURSING HOME SILVER SPRING MONTGOMERY If Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2M F Months Deys Hours Min. Yrs. 84 **Director** 227-18-1820 Nov 5, 1915 VA Usuel Residence of Decedent with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified as MD Montgomery Silver Spring 1 ☐ Yes 2√ No Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 2700 Barker Street 20910 USA Funerai 12. Wes Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: white b 3X Widowed 4 □ Divorced Completed permit. Pages 1 and 2 should be filled within 72.1 Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturally or other traumatic event, the Modell Once. 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 nursing asst health 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Canada 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk 19e. Informent's Name/Relationship (Type, Print) unk 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Buriel 2 Cremetion 3 Removel from State
4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licensee
Ronald S. Wade, Ronald S. Wade Director

Ronald S. Wade Director

State Anatomy Board 655 W.

Baltimore, MD 21201

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. 655 W. Baltimore Street Approximete Intervel Between Onset and Deeth **Physician** Pneumonia Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical 2 WKS Examiner Due to (or es e consequence of) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of) Physician/Medicai that Initieted events Due to (or es e consequence of): resulting in deeth) Lest Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown east-Completed by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy 2 100 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicel exeminer? 8 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 Naturel n 24 hours after death.

• Funeral Director: After the function by the function of the functin 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted. edical completely (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. within 2 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D19609 TULL 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 3503 PERRY STREET. MOUNT RAINIER, MD 20712

State Registrar RAMAN R. TULI

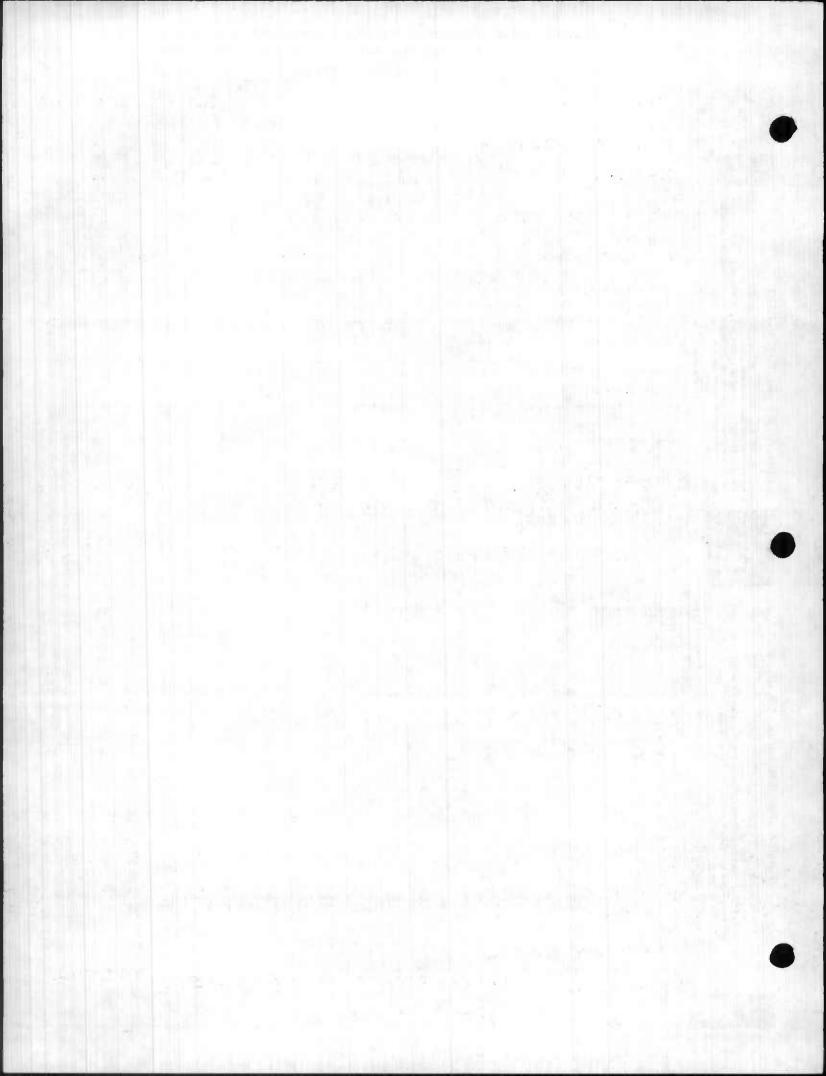
31. Date filed (Month, Dey., Year)

OCT 13

2000

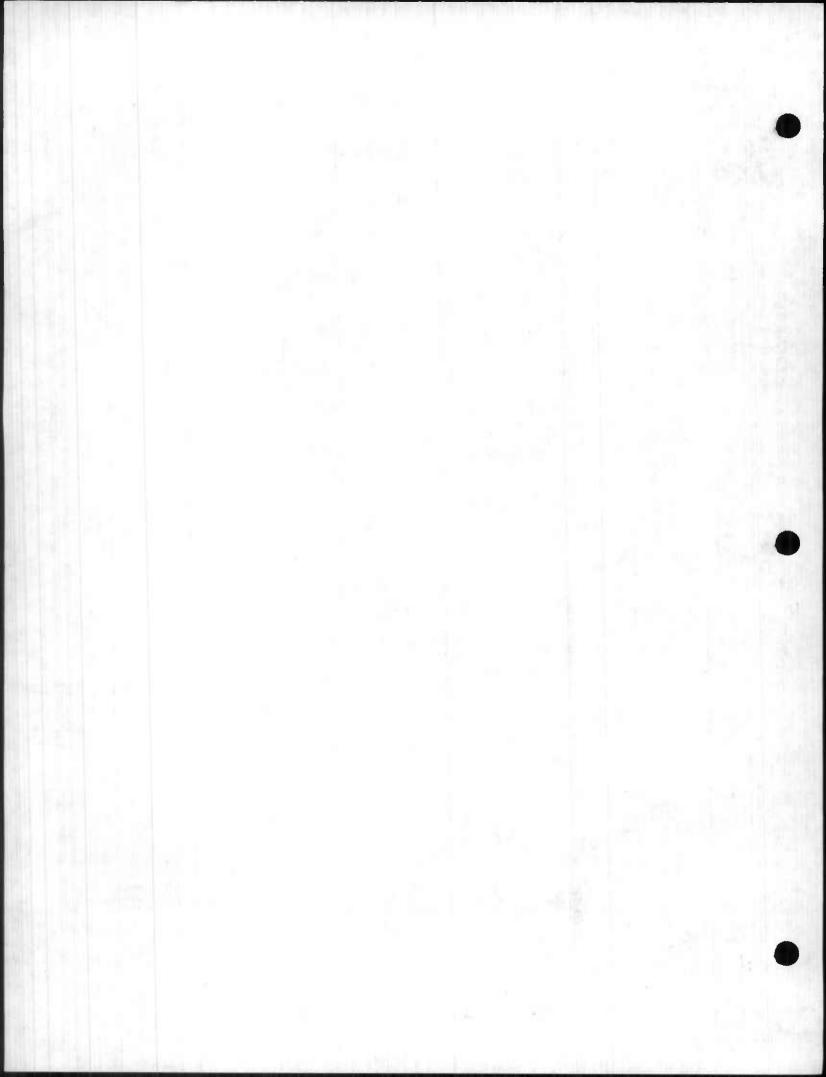
32. Registrer's Signeture

JAMEN



State of Maryland / Department of Health and Mental Hygiene 32384

				Cer	tificate	of D	eath		Reg. No.		2001	
0.		1. Decedent's Neme (First, Middle, Las						2. Dete of Do Month	eeth Day	Yeer	3. Time of Death	
	nysician Medical		Sheila Anr	n Marti	n			Octobe		2000	09:24 A.M	
	kaminer	4e Facility Neme (If not institution, give	street end number)			4b.	City, Town, o	or Location of Dee	h 4c. County	of Death		
		Maryland	General Hospi	tal		0.10	Balti	more	N/A			
Fur	neral	5. Social Security Number 6. Se	ex 7. Age (In yrs.		If Under 1 Months	1 Yeer Days	If Under 24 H Hours Mi		rth av Year)	_	lece (Steta or Foreign	
Dire	ector	214-68-4422	□M 20XF 44	Yrs.	Working	Days	110013	1-1	0-1956	Coun	"" Md	
р.		Usuel Residence of Decedent 10a. Stete 10b. County	40- 0	Town as La	antina.					I	Od tasida Cibal imina	
Manyla	or or	Md N/A		y, Town or Local							0d. Inside City Limits 1 ☑ Yes 2 ☐ No	
the 1	Director	10e. Street and Number			10f. Zip 0	Code			10g. Citizen of Whet Country?			
1215-0020 within 72 hours after death with the Maryland ene.			enue			217			U S	A		
ter des	iner must Funeral	11. Merital Stetus	12. Was Decedent Ever in U Armed Forces?	,S. 13. V	Vas Decede f Yes, specif	ent of Hisp fy Cuben,	anic Origin? Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		e - America ck, White,		
21215-0020 d within 72 hours afte	þ ý	1 Never Merried 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Detes:	1	1 □ Yes 2)	No No	Specify:		Specify	v: B1	ack	
15-002 n 72 hours	ted la	15. Decedent's Ed	ucation	16a. Deced	lent's Usual	Occupati	on ring most of w	working	16b. Kind of B	usiness/Inc	dustry N/A	
within 7	r, the Medical	(Specify only highest green [Seementary/Secondary (0-12)]	Collega (1-4or 5+) 1 Year	life. L	DO NOT use	e ratired)	ang most or w	N/A			N/A	
DOF		12th grade	1 Year				O. Bitash and a Bi	lama (Final Adiabet)	Maidan Cuman		1	
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aryla should nd Men	T met			401 14-75		/0.		Oliver	O' T	Ct-t- Ti-	0.4.1	
War 12 sh	Ther	19a. Informant's Neme/Relationship (7						Rural Route Numi				
	other	Ethel Martin -Mot		2/24 Place of Dispos	Parw(ood F	venue	Baltimo	re, Md	21217	wn State	
Pages nent of H	6	20e. Method of Disposition 1 Disposition 3	Removel from State	annelery, cren	netary or on	let blece)		1				
tiner tant:	lury	4 □ Donation 5 □ Other (Specify		ng Mem				10-14-00	Randall	stown	, Md	
Baltimore, permit. Pages 1 at Department of Hea	any injury o	21. Signature of Funerel Service Licans	R a	22	March March							
		23a. Parii. Enter the diseese, or comp shock, or heart (allure. List only o	12. Harr	w			sh Ave		timore,	Md	21215 Approximata	
Exam e executed ilen and	rial-transit Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or rinjury	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							rec		
Centif	· ×	that initiated events resulting in deeth) Last	Due to (c	r as a consequ	uenca of):							
death death	ned for us	Part II. Other elanifloant conditions on	entributing to death but not rec	ulting in the us	ndarhiino oa	use niven	In Part I	23h Die	I tobacco use co	ntribute to	the cause of death?	
0 6	atache Phys	Pert II. Other significant conditions co	ontributing to death but not res	uiting in the ur	ndanying ca	iuse given	in Pert 1.				bably 4 Unknown	
ecords law requires as been sign	2 should be pleted by	Vesy W			913		114		s an eutopsy ormed?	eve	ere eutopsy findings eilable prior to mpletion of cause death?	
= F #	Com							1,28	Yes 2□No	1,0	o Yas 2□ No	
Of Vital Physician: Th this certificata	Be Be	25. Was case referred to medical examinar?						Death (Check only	ona)			
Physic this ce	5	1 X Yes 2 No	Hospital: 1 ☐ Inpatiant 2	ER/Outpatien			4 LI Nursing	g Home 5□ Res	idanca 6 Oth	nar (Specif	y)	
Eng Affe		27. Mannar of Death 1 Natural 5 Pending 2 Accident Investigation	28e. Data of Injury (Month, Dey Year)	28b. Time of Injury	28 M	3c. Injury e Work? 1 ☐ Ya	ot as 2□No	28d. Describe	how injury occur	berr		
5 8 5 B	ed in by the funers Certification:	3 Suicide 6 Could not be detarmined	28e. Pleca of Injury - At h building, atc. (Specif		eet, factory,	office			(Street end Numi own, State)	ber or Rura	I Route Number,	
- Hospital 24 hours - Funeral	lical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	velcian: To the best of my knowliner: On the basis of examination and manner steted.	wiedge, deeth	occurred e	t the time in my opir	, date end pla nion, death od	ice, end due to the courred at the time	causa(s) and m , date end place,	enner es s and due to	tated. o the cause(s)	
To the within 2	Me	29b. Signature end title of certifier	4	Table 1 Fe	29c.	License	number		29d. Date signe	ed (Month,	Day, Year)	
+ 3 =	0	styst ,		Octo	ber 1	10, 2000						
-		30. Name and addrass of person who o	1 1.			·	L D-7	4-2		2122	1	
		Stephen S. 12 31. Date filed (Month, Day, Year)	32. Registrar's Signe		eilli S	Lree	r, Bai	timore,	maryland	2120)T	
	State	OCT 1 3	2000 1 /24-4	Jan A	2	hon.	100					

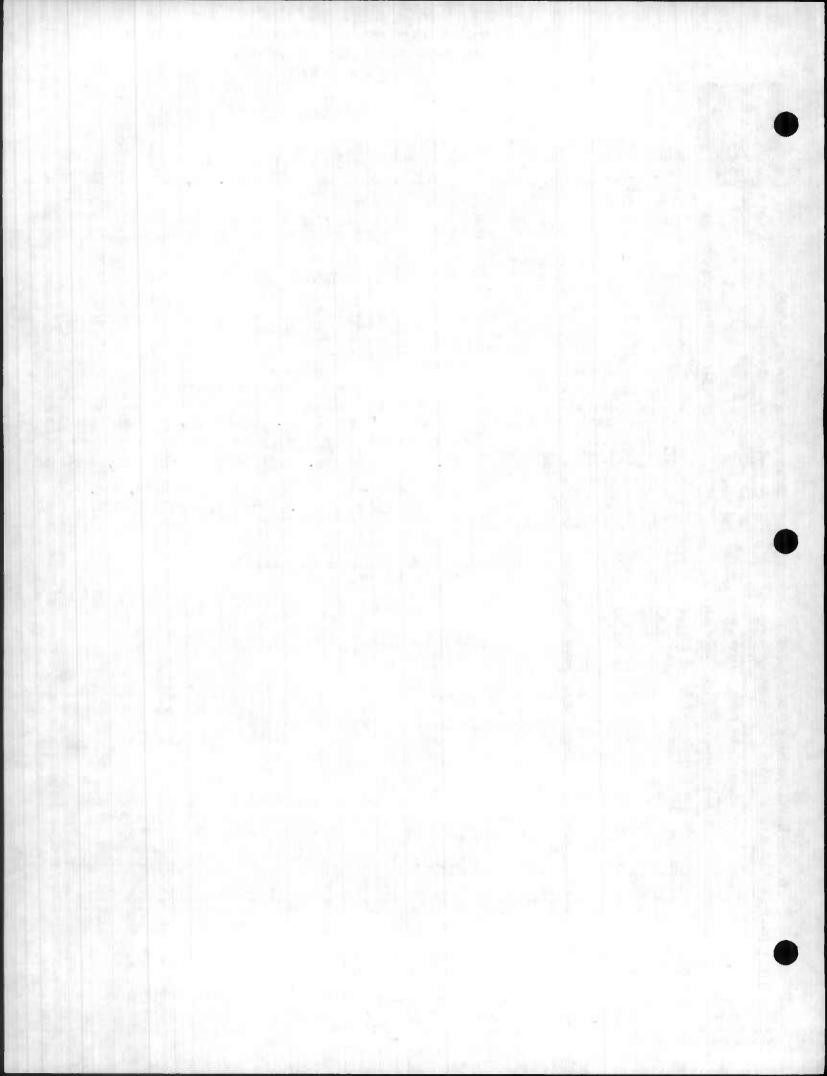


State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Certifica	ate of	Death		Reg. No.	3 3 2 3 0 3
	Dhuaisian	1. Decedent's Nama (First, Middla, La	ist)		/	20	6	2. Date of De Month	ath Day	3. Time of Death
	Physician /Medical	STELLA	Carried Baseline		/1	HST	ERKA	actobe	2 06 %	2000 10135AM
	Examiner	4a Facility Name (If not institution, give	re street and number)	Nan	1	1	40. City, Town, or L	ocation of Death	4c. County	of Death
27		VOUNS HOME	US PAYVIKU	SMEN	rest (FREK	BALTZ	MORK		N/A
	Funeral			In yrs. last bir	Monti	der 1 Yaar hs Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Year)	Birthplace (State or Foreign Country)
	Director	17.2-18-7365	1□M 2 只 F 82		Yrs.				1,1917	Pennsylvania
2		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Tow	n or Location					10d. Inside City Limits
2	a de la	The Salt of		oc. City, Tow	n or Location					18 Pras 2 □ No
2	28a-f show routed at		/A				altimore			
the Mada	ritems 23a or 28a-fa instrument benedited Funeral Director	10e. Street and Number			10f.	Zip Code		M. J. G.	10g. Citizen of V	
÷ ÷	23 E	3132 O'Donnell	Street				21224			1 States
9	floral land	11. Marital Status	12. Was Decedent Eve Armed Forces?	ar in U,S.	13. Was De If Yas, s	cedent of hopecify Cubi	lispanic Origin? (Sp an, Maxican, Puerto	pecify Yes or No Rican, etc.)		a - Amarican Indian, k, White, atc.
20	P F	1 Nevar Married 2 Married	1 Yes 2X No		1 ☐ Yas	5 28 No	Specify:		Specify	
21215-0020	d by	3 Widowed 4 □ Divorced	Yaar or Datas:							White
2 5	ygiene. ner than "naturn rt, tre throidea Completed	15. Decedent's E (Specify only highest gra		16a.	Giva kind of	work done	during most of work	king	16b. Kind of Bu	usinass/Industry
12	then then	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NO		<i>a</i>)			
CA C		8 Years 17. Father's Nama (First, Middle, Last	1		Homei	maker	18. Mother's Nam	o /First Middle	Own Ho	
anc	2 × 0	Zachary Nebesn								6)
7	Ment Ment To	*	*					ret Luc		
Maryland	0 6 8	19a. Informant's Name/Relationship (Dolores Misterka	**		_		and Number or Ru 11 Str.			
	item 27 other tr				Disposition (II Der.	Date		City or Town, State
Baltimore,	0 = -	20a. Method of Disposition Burial 2 Cremation 3		camete	ry, crematory o	or other pla				
E E		4 Donation 5 Dolher (Special		st. s	A		em. 10/10	/2000	Baltin	more, Maryland
Balt	Depertment Important: Il any Injury o	21. Signature of Futural Sarvice Lice	nsée /	10			ss of Facility Funeral	Home of	Dundall	k Inc
LLJ &	0538	1 hall	11-12	VII			Ave. Du			
4		23a. Pad1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	ceath. Do	not enter the n	node of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
P	hysician		. /	1	_					Onset and Death
- 1000	Medical	Immediate Cause (Final disease or condition	- HEDA	THE	(17%	240:	SILS			VEAKS
-	xaminer	resulting in death)	Du	e to (or as a	consequence	of): //				
/ 5	in and ial-transit		. HEAR	7771	FAI	Rux	F			LWEKK
	ician and burial-transit al Examí	Sequentially list conditions,	Du	e to (or as a	consequence	of):				
90,	burial Burial	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	6							
68760,	physicis s the bu	that initiated events resulting in death) Last	Du	e lo (or as a	consequence	of):				
	a as		d							
O. Box	ettendin for usa									
0. 4	by the e tached i	Part II. Other significant conditions of	contributing to death but r	not rasulting li	n tha undarlyin	ng causa giv	van in Part I.	23b. Did	tobacco use cor	ntributs to the cause of death?
Q. 2	ate has been signed by the ettendin. page 2 should be detached for usa. Completed by Physician/N	Dissentalate	TAKIAL	1accul	01.	Acres 1	steral	10	Yes 2 No	3 Probably 4 Unknown
Records, P	be del	1300 CO 140 141C)	150 (1311)	MSUM		Tynir	TILL		e continues	
Orc	been si should								an autopsy med?	24b. Were autopsy findings available prior to
e C	has be ge 2 sh mple									complation of causa of death?
E .	page page							70	Yes 2□No	1 □ Yes 2 No.
Vital Records,	s certificate director, pag To Be Co	25. Was case referred to medical examiner?			51751		26. Place of Dea	th (Check only	one)	
of Vita	this ce al direc	1 Yes 2 No	Hospital: Impatient	2 ER/O	itpatient 3	DOA Oth	ner: 4 Nursing H	ome 5 Resi	dence 6 Oth	er (Specify)
n of	h. After th funeral tlon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Dey Y	(ear) 28b.	Time of njury	28c. Inju	ry at rk?	28d. Describe	how injury occur	red
Vision	death. ctor: At y the fu	2 Accident invastigatio	n		М		Yes 2□No			
	er de recto by t	3 Suicide 6 Could not b		- At home, fa	ım, street, fac	tory, office		28f. Location (City or To		per or Rural Route Number,
io is	Ce in Ce									
Hospital	n 24 hours after death. • Funeral Director: After tpletely filled in by the funeral edical Certification:		nysician: To the best of miner: On the basis of ex							
	within 24 hours after deat To the Funeral Director: completely filled in by the Medical Certifical	one)	and manner state	d.						
Tothe	To the com	29b. Signature and titla of certifier				29c. Licens	se number		29d. Date signer	d (Month, Day, Year)
		12m				2	1010		COTOB	EL 11, 2000
	IV	30. Name and address of person who	completed cause of deal	h (Item, 23a)	(Type, Print)	1		11	11	9 (2
	I. Comment	EVELUW ME	NTARI MI	7741	CASE	RNT	VENUE B	HETMOR	E MARY!	AND 21224
100	State	31. Date filed (Month/Day, Year) QCT 1 3 200	32. Registrar's	Signature	E	P	•		, ,	
	Registrar	441 7 9 700	IU JOHN	1	1	0120 1				

DHMH 16 Rev 6/95

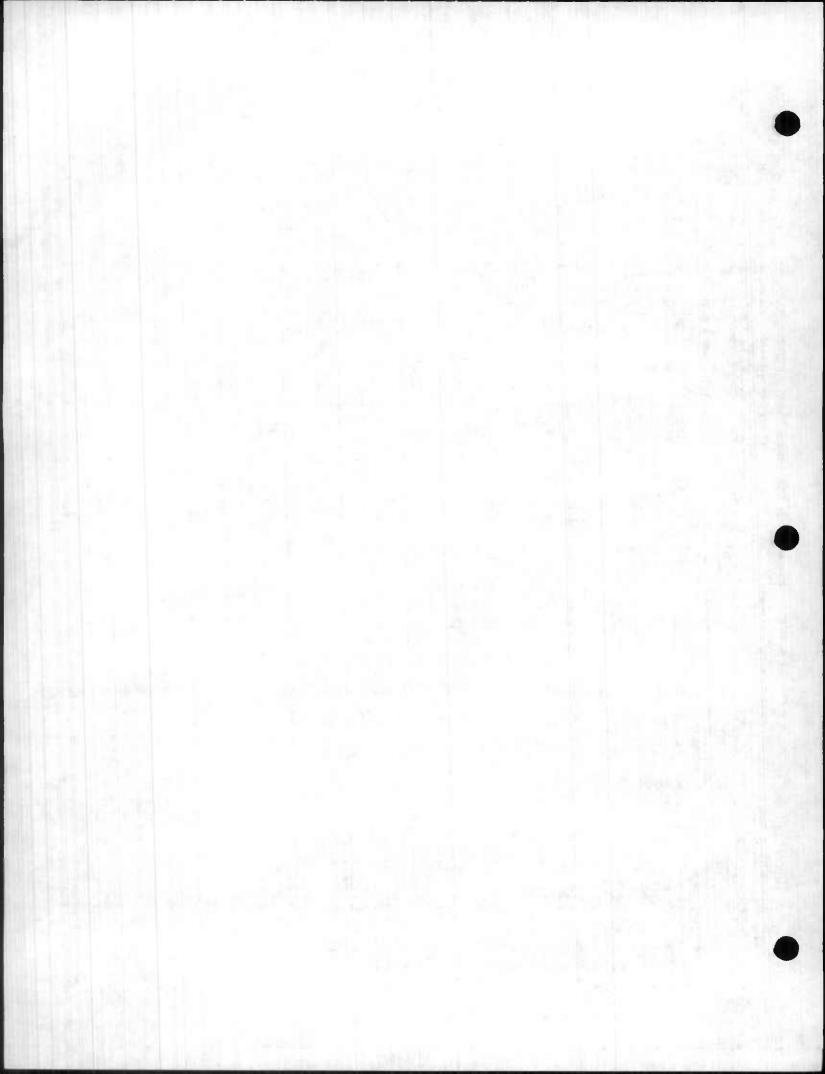
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State of Maryland / Department of Health and Mental Hygiene

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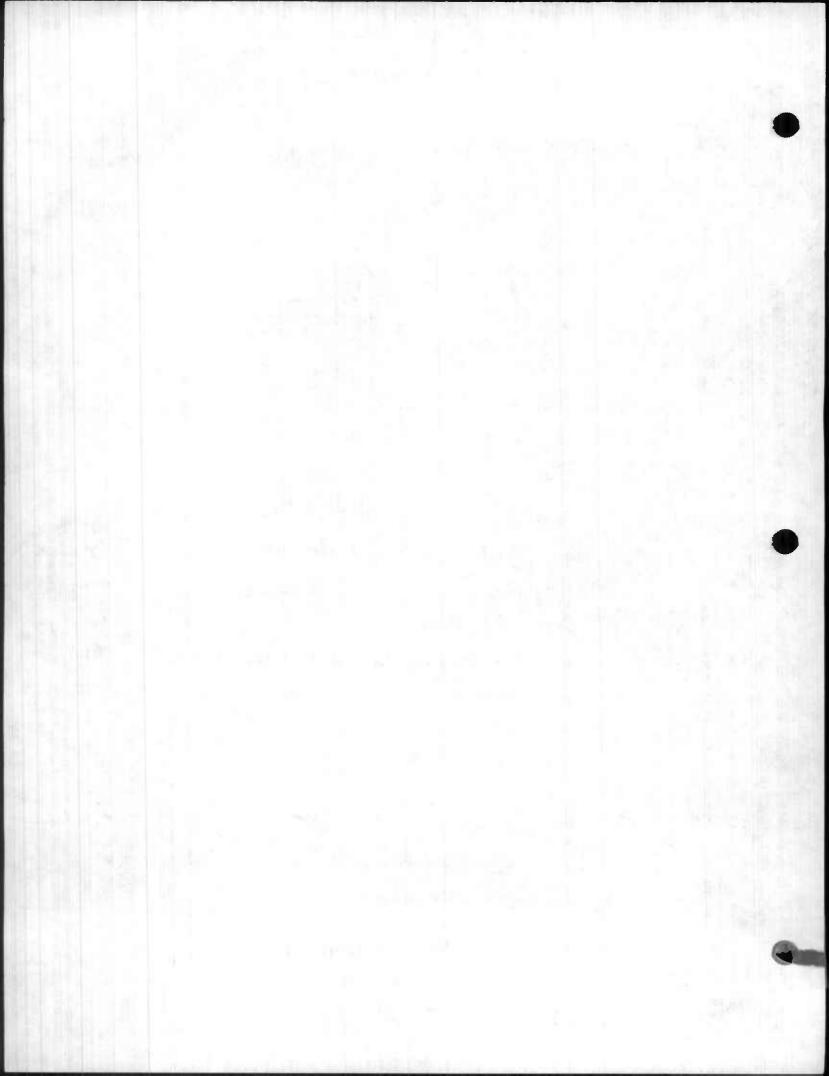
			C	ertificate of	Death	Re	g. No.	02000	
Dhusiaian	1. Decedent's Name (First, Middle, Li		13 1-13		1,112	2. Date of Death Month	Day Year	3. Time of Death	
Physician /Medical		Lillian V.	Mallon	ee		October	12 2000	4:30 A.M.	
Examiner	4a Facility Nama (If not institution, gi					or Location of Death	4c. County of Deat		
	Anne Arundel 5. Social Sacurity Number 6.	-		(av) If Under 1 Year	Annapo			Anne Arundel	
Funeral Director		1 M 280 F 8:	yrs. lest birtho	Months Days		s. Date of Birth in. (Month, Dey, August 2	Year) 9. Bin 2,1917 Mā	hplace (State or Foreign ountry) aryland	
B & w	10a. State 10b. County	100	. City, Town o	r Location				10d. Inside City Limits	
or 28e-f sh be notified.	Maryland Anne Ar	undel .	Arnold	1.00 70 0.10				1 □ Yas 2 No	
	10e. Street and Number 182 Severn Way			10f. Zip Code 2101			10g. Citizen of What Countr		
21215-0020 d within 72 hours after death vipinite. e than "natural", or flams 23a the Medical Examiner must	11. Marital Status 1 Never Married 2 Married 30 Widowed 4 Divorced	12. Was Decadent Evar Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	in U,S.	13. Was Decedent of If Yes, specify Cui	oan, Mexican, Pu	(Specify Yas or No- erto Rican, etc.)	14. Raca - American Indian, Black, White, etc. Specify: White		
od within 72 ha sysiene, we their harum it, the Medical I	15. Decedent's E (Specify only highest gr		16a. D	ecedent's Usual Occu	pation during most of	vorking 1	6b. Kind of Business/	Industry	
121 Men Men mple	Elementary/Secondary (0-12)	College (1-4or 5+)		iva kind of work done le. DO NOT usa retin	9d)		0		
	12th 17. Father's Name (First, Middla, Las.	1	П	omemaker	19 Mathada N	lame (First, Middla, M	Own Hom	<u>ie</u>	
Maryland 32 should be the n and Mental Hy ris marked othe resumatic event		John Lample				Rosa Eizen			
Mar nd 2 sho alth and 27 is my	19a. Informant's Name/Relationship John Mallonee	(Type, Print) Son		lailing Address (Street Severn Wa		Rurel Route Number, nold, Mary			
Baltimore, semit. Pages 1 a populment of Her inportant: If them my Injury or other nice.	20a. Method of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Other (Speci	Removal from State	camatery.	isposition (Neme of cremetory or other plants idge Ceme			Oc. Location - City or Baltimore	Town, State	
Balti permit. Departm importar and injury	21. Signature of Funaral Service Lice		1	22. Name and Addi	ess of Facility	Gonce Fu	neral Home	P.A.	
W.	23x Part Enter the disease or one	The ations that raused the	The second second			way Balti		Z1ZZ5	
Dhusisian	23a. Part1. Enter the disease, or con shook, or heart failure. List only	cause on each line.	death. Do not	enter the mode of dy	ing, soon as care	nac of respiratory erre.	1	Interval Between Onset and Death	
Physician / /Medical	Immediate Cause (Final disease or condition	SEPTI	c SH	nc 16				12H	
Examiner	resulting in death)	Due	to (or as a cor	nsequenca of):			1	110 704	
executed in end itel-transit	Sequantially list conditions,			OLECYST sequence of):	ITIS			48-724	
68760, ifficate be executed g physician end as the buriel-transit edical Examir	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents	c. 1817		7 S sequence of):				48-72"	
. Box 68760, death certificate be execut on attending physician and by for use as the buriel-transiciary/Medical Exam	resulting in death) Last				15/LOW	GRADE	SI BLEED	4-6 m	
Geath death death death	Part II. Other significant conditions	contributing to death but no	resulting in th	ne underlying cause o	iven in Part I.	23b. Did tot	ecco use contribute	to the cause of death?	
P.O. de by the detache	Anemia of ch	onic disease	, at	rial Fib	Matic	10 Ye		robably 4 Unknown	
Should should	consestive hea	nt failure	, tu	buloville	us	24a. Was an perform	ed?	Were autopsy findings available prior to completion of cause of death?	
f Vital Rec yelden: The law is certificate has director, page 2 To Be Comp	ademona Sp	partial con	domi	1998; P	eigh. no	ecusptly 10 Yes	2 KINO	1 ☐ Yes 2K No	
	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outp	atient 3 DOA	hor:	Death Charle of ly one Home 5 Resider		neifu)	
ng Ph ther th inerel	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea		e of 28c. Injury	ury at ork?	28d. Describe ho		cnyj	
Division of the or attending P and or attending P is after death. al Director: After the ind in by the funeration: Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	OB Disease Laine	At home, farm		Yes 2 No	28f. Location (Str. City or Town,	aet end Number or R Stete)	ural Route Number,	
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	(Check only 2 Medical Exac	nysician: To the best of my miner: On the basis of exam	knowledge, d	eath occurred at the r	ime, date and pla opinion, death o	ace, and due to the ca ccurred at the time, da	use(s) and menner as te and place, and due	s stated. e to the cause(s)	
thin 2 the mple.	one) 29b. Signature and title of-certifier	and manner stated.		29c Licer	se number	29	d. Date signed (Mont	th, Dev. Year)	
5 7 5 8 T	· Qn	L MD			3199		10/12/0	06	
6	30. Nama and address of person who ANDREW GORDO	completed cause of death	2 11	pe. Print) fice (Pku	y Stell	O Annipo	olis Md	21401	
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's S		A ho	20 85				



		ate of Maryland /	Certificate of		Re	g. No.	32387							
Physicia	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Ya	3. Time of Death							
/Medic	Coommo	Mercer			Oct.]	1,2000	12:01pm							
Examine	4n Frailine Name (Mant Institution also stands	and number)		4b. City, Town, or Lo	ocation of Death	4c. County of D								
	Future Care Nur	sing Home		Sever	naPark	Anne A	Arundel							
Funeral	5. Social Security Number 6. Sex	7. Age (in yrs. last b	irthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (Stata or Foreign Country)							
Director	237-46-2306 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	70	Yrs.	1700.0	Sept.]	3,1930	N.C.							
2 .	Usual Rasidence of Decedent	10- Ch. To					10d. Inside City Limits							
abon abon data	10a. State 10b. County	TOC. City, Tov	wn or Location											
the Maryla 28a-f sho notified at	MD Anne Aru	ndel	Severna	Park			1 ☐ Yes 2½ No							
6 6 6	MD Anne Aru		10f. Zip Code		10	g. Citizen of What	Country?							
23s	106 Manns Rd		2]	1146		U.S.A	A .							
1 000	11. Marital Status 12. W	as Decedent Evar in U,S. med Forces?	13. Was Decedent of H If Yes, specify Cub:	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian, /hita, etc.							
8 4 g	1 Nevar Married 2 Married 1	Yes 2 No Yes, Give	1□ Yas 2⊠ No				ro American							
En,	3 Widowed 4 Divorced Ye	ar or Dates:												
dice the said	15. Decedant's Education (Specify only highest grade com		 Decedent's Usual Occup (Give kind of work done lifa. DO NOT use ratire 	eation during most of work	ing	6b. Kind of Busine	ess/Industry							
E R B F		ollega (1-4or 5+)												
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1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	17. Fathar's Name (First, Midd/a, Last)			18. Mother's Nam										
Men Men out	Tommie Mercer			Bloome										
the state of the s	19a. Informant's Name/Relationship (Type, Pr	int) 19	b. Mailing Address (Street	and Number or Run	al Route Number,	City or Town, Stat	a, Zip Coda)							
and and and na 27 ner to	Bernice Mercer/ W		.06 Manns H	RD Glen		, MD 2]								
A Office A	20a. Mathod of Disposition 1 □ Burial 2 □ Cramation 3 □ Remove	comet	of Disposition (Name of ery, crematory or other pla	ce)	Date	20c. Location - City	or Town, State							
Pag mit m	4 Donation 5 Other (Specify)		en Mount (Cemetery	Oct18,2	2000 Bal	Lto.,MD							
Portuge St	21. Signature of Funeral Service Licensed 22. Nama and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME													
Sales	10/18 X-01	21/2		B. SCRU PRESTO										
	23a. Part L Enter the disease or complication shock, or heart failure. List only one cau	causad the death. Do					Approximate							
Physician							Interval Between Onset and Death							
/Medical	Immediate Cause (Final disease or condition resulting in death) Encl Stage Renal disease Due to (or as a consequence of):													
Examiner	disease or condition resulting in death)													
		Coronari	Consequence or).	Dinear			many years							
uted d ansit	b. Sold way cased													
n an ial-tr	Sequentially list conditions, if any, leading to immediate	1 ks Desi	C 40 C 4 20				Meny Gens							
cata be executed physicien and sthe burial-transit	cause. Enter Underlying Cause (Disease or Injury that initiated events	Dia 10/07 000	consequence of):				1							
Phy ficat	rasulting in death) Last	Non Fraul		I- Dich	D= 0000	.t.	Man years							
as thet the death certificated by the attending be deteched for use a	d Part II. Other elgnificant conditions contributi	NON ON THE	in sepende	12162	ores (lead		00							
atter after					l an prite									
che che	Part II. Other significant conditions contributi	ng to death but not resulting	in tha undarrying causa gr	en in Parti.			oute to the cause of death?							
thet dete					101	s 2□No 3[Probably 4 Winknown							
The law requires that the death certification is the second secon					24a. Was a	autopsy 2	4b. Were autopsy findings							
v require been si					perform		available prior to completion of cause							
hes law							of death?							
					1 □ Ye	s 200 No	1 ☐ Yes 2 ☐ No							
	25. Was case referred to medical examiner?	s1.	04	26. Place of Deal	h (Check only on	a)								
	1L) Yas 2LANO	1 ☐ Inpetient 2 ☐ ER/C	outpatient 3LI DOA			nce 6 Othar (Specify)							
D 2 2	27. Manner of Death	. Data of Injury (Month, Day Year) 28b.	Time of tnjury 28c. Inju		28d. Describe no	w injury occurred								
Attending at deeth.	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 No	001.1 11 10	404 6-	0 - 10 - 11							
or Attending I after deeth. Director: After In by the fune	284 1 Naturat 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homlcide determined	 Place of Injury - At home, in building, etc. (Specify) 	larm, street, factory, office		City or Town		or Rural Route Number,							
The second														
tosp t hor une ely fi	(Check only 2 Medical Examiner: 0	To the best of my knowledgen the basis of examination a	pa, death occurred at the ti nd/or investigation, in my	me, date and place, opinion, death occur	and dua to the cared at the time, do	use(s) and manna ata and place, and	r as stated. due to the cause(s)							
	one) air	nd manner stated.												
To To	29b. Signature and title of certifier) MD	29c. Licens	se number	2	9d. Date signed (N	nonin, Day, Year)							
	10001.		104	0317		10/12/00	DOLLAR TO							
U	30. Name and address of person who complete	ed cause of death (Item 23a)	(Type, Print)	CO 10	. 4. 3	144								
	MIRTA M. NUSAIREE	ed cause of death (Item 23a) 7545 value 32. Registrant Signature	sed profe blu	, Ocals	roune,	706/								
Stat	31. Date filed (Month, Day, Year)	32. Registrare Signature	A So	mk.										
Registra	OCT 1 3 200	hat year	La tal											

DHMH 16 Rev 6/95

GEORGIE MERCER



Registrar DHMH 16 Rev 6/95

To the Hospital within 24 hours a To the Funerel D

29e. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Dey, Year) OCT 1 3 2000

Dennis

hute mo

32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the cause(s) and manner as stated.

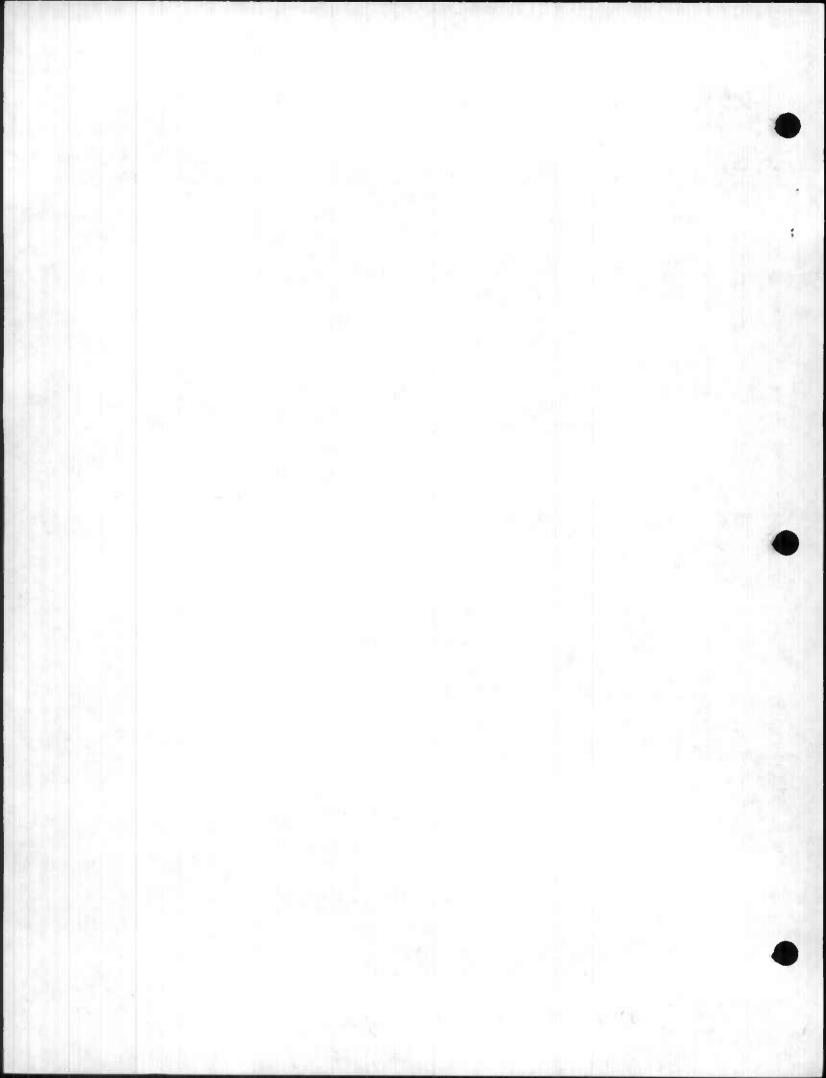
Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the ceuse(s) and menner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Dey, Year)

October 07, 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Deeth Yeer Sahel Nor 11,2000 October 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Keswick Multi Medical Center Baltimore N/A 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdey) Birthplace (Stete or Foreign Country) 1 □ M 2 🖾 F Months Deys Hours Yrs. 213-46-0983 91 November 25,1908 Milwaukee Wisconsin Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo Baltimore Co. Maryland Timonium 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 202 Eastridge Garth 21093 United States of America 12. Wes Decedent Ever in U,S Armed Forces? 1 □ Yes 2 以 No If Yes, Give Yeer or Detes: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bieck, White, etc. 1 Never Married 2 Married White 1 Yes 2 XNo Specify: Specify 3 XWidowed 4 ☐ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 n/a Home Maker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Winfield O'Connell Louise Cetner 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Mrs. Karen A. Beckhardt(Daughter) 233 East Timonium Road Timonium, Maryland 21093 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremetion 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) Ramsey Cemetery 10/16/2000 Ramsey, (Fayette Co.) III. 21. Signature of Funeral Service Licensee Jeffrey L. 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204-2515 or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, ist only one ceuse on each line. CONGESTIVE HEART FAILURE Immediate Ceuse (Finel diseese or condition resulting in death) Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? ZHEIMERS 1 Yes 21 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? 210 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) 217 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yeş 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 1 Naturel 28a. Dete of injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

Examiner Box 68760. P.O. Records.

The law requires that the death certificate be executed attending physician and for use as the burial-tran signed by the a page 2 s this certificate has Division of Vital or Attending Physician: director, the funeral After 24 hours after death. filled in by Hospital

Physician

/Medicai

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notined at

death

within 72 hours after

Hygiene.

permit. Pages 1 and 2 should be filed wit. Department of Health and Mantal Hygiens important: if fam 27 is marked other tha any injury or other traumatic event, the once.

Physician

/Medical

Examiner

Physician/Medical

Completed by

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Certification: To

Medical

29a. Certifier

(Check only one)

Baltimore, Maryland 21215-0020

Director

Funeral

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State Registrar

2 Medical Examiner: On the besis of exe end menner steted

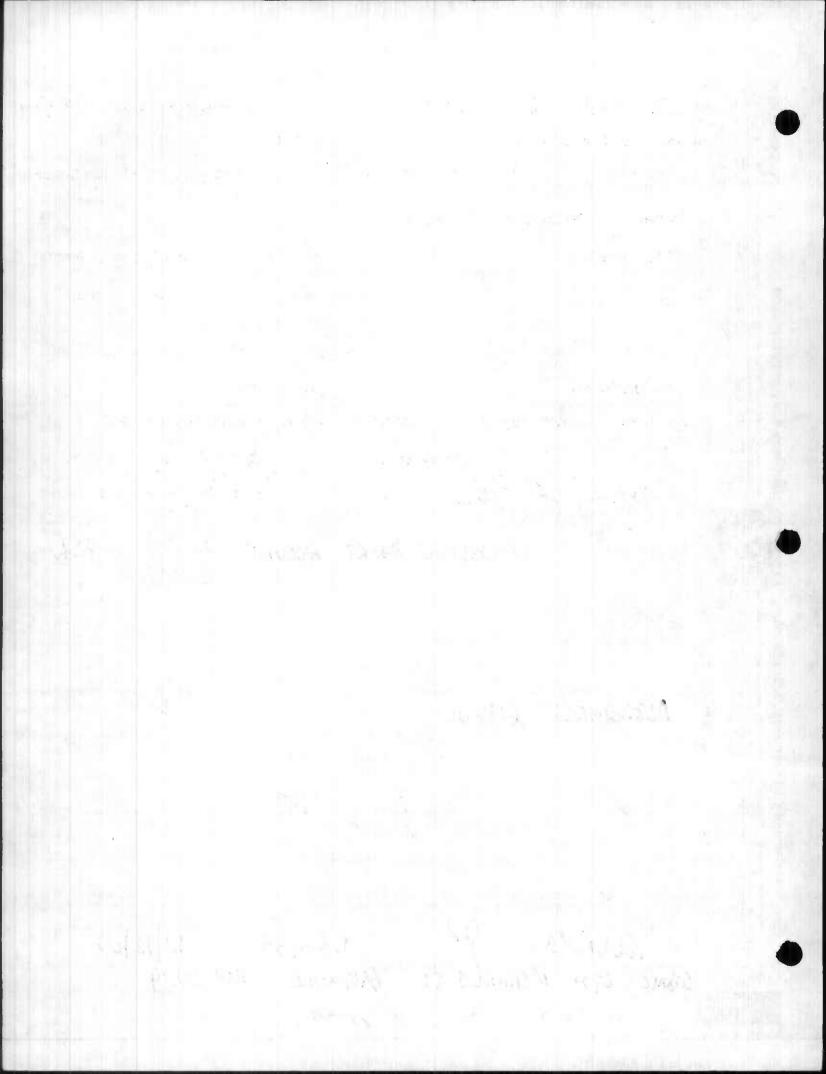
Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s)

29d. Dete signed (Month, Dey, Year)

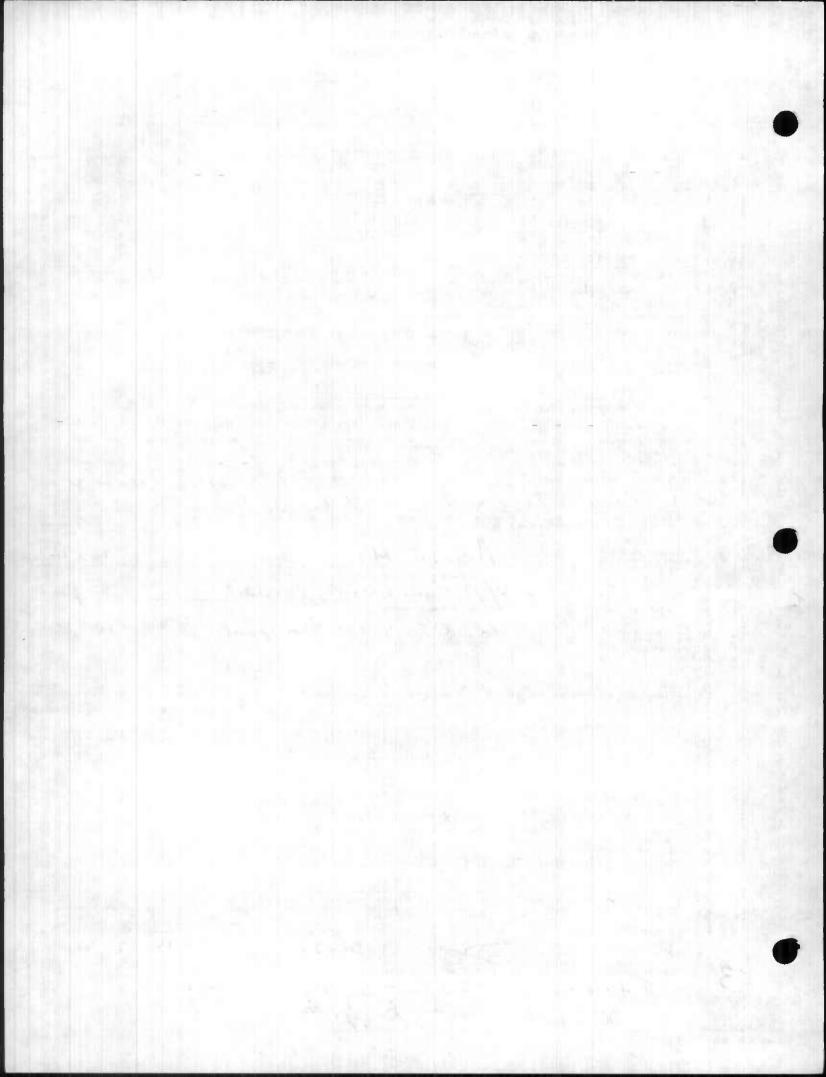
30. Name end eddress of person who completed cause eth (Item 23a) (Type, Print) MIMORE MO 21204 CHADLES

31. Dete filed (Month, Day, Year) 2000 32. Registrar's Signeture Deneral



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Month **Physician** eNa 10-2000 9:45 a.m. /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore <u>St Joseph Hospital</u> Birthplaca (Stata or Foreign Country)
 Egypt If Undar 1 Year 8. Date of Birth (Month, Dey, Year) 6-26-1924 5. Social Security Number If Under 24 Hrs. 7. Aga (In yrs. last birthday) **Funeral** Days Hours Months 081-82-0214 1□M 2ØF Yrs 76 Director Usual Residence of Decedent with the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yas 2 No **Funeral Director** Cockeysville Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of Whel Country? permit. Peges 1 end 2 should be filed within 72 hours efter death with Department of Health end Mental Hygiene.
Important: If them 27 is marked other than any Injury or other traument. ò 21030 Egypt items 23a 10591 Topsfield Drive 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ Never Married 2 ☐ Married specify: White 1 Yes 2 No Specify: by 3/D Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondery (0-12) College (1-4or 5+) N/A N/A N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Turk Aly Naquib 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) 10591 Topsfield Drive Cockeysville, Md Salem Wahby -Son-In-Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 □ Other (Specify) King Memorial Park 10-13-00 Randallstown, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4300 Wabash and. Fuguera 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Death Physician /Medical Immediate Cause (Final 1-2 Hours disease or condition resulting in death) Examiner Physician/Medical Examiner Physician: The lew requires that the death certificate be executed es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last P.O. Box 68760, 12RVICAL 40 Due to (or as a consequence of) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings Completed 24a. Was an autopsy available prior to completion of cause of deeth? page 2 s 1 Yes 2 No 1 ☐ Yas 2 ☐ No this certificete 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To To the Heapital or Attending Ph within 24 hours after death. To the Funeral Diractor: After thi completely filled in by the funeral 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be detennined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number D1422 20.12.2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 BASTIBRU Blus BALT ~ 21221 31. Date filed (Month, Day, Year) 32. Registrar's Signatura souls Janeva. 13 2000 Registrar



NIEMAN

State DHMH 16 Rev 6/95

Registrar

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31. Data filed (Month, Day, Year)

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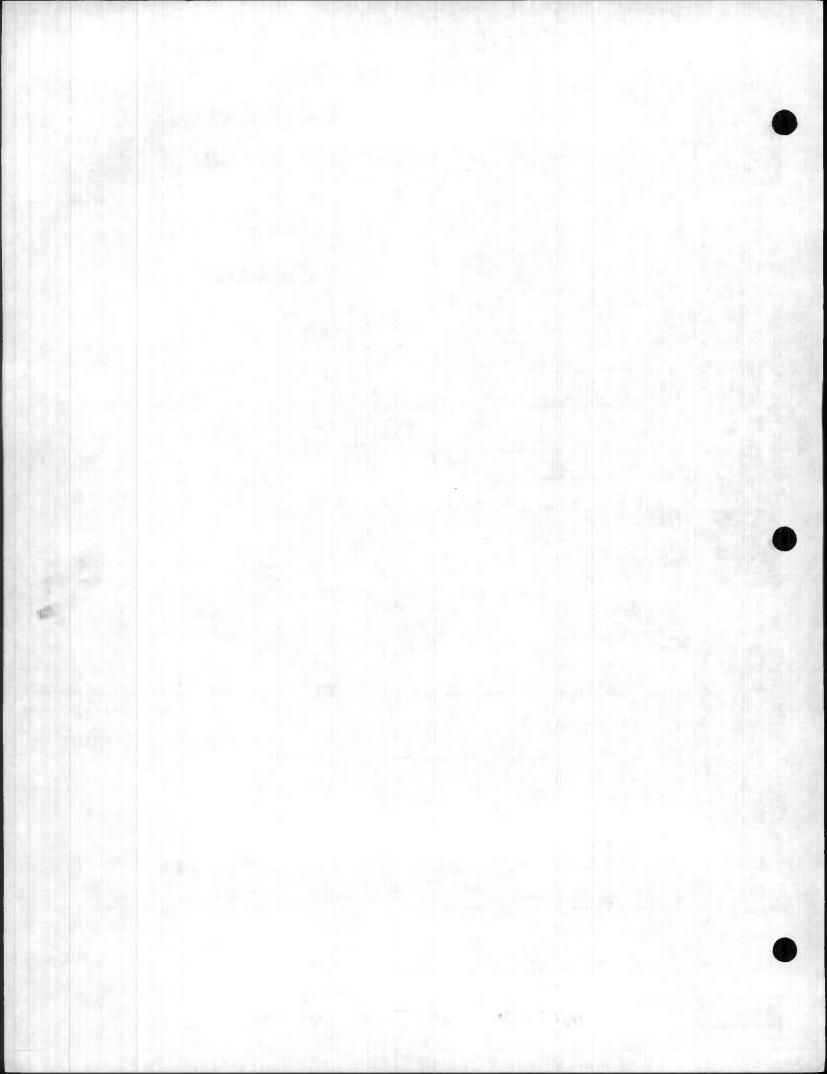
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BALTIMORE, MD 21237

29d. Date signed (Month, Dev. Year)

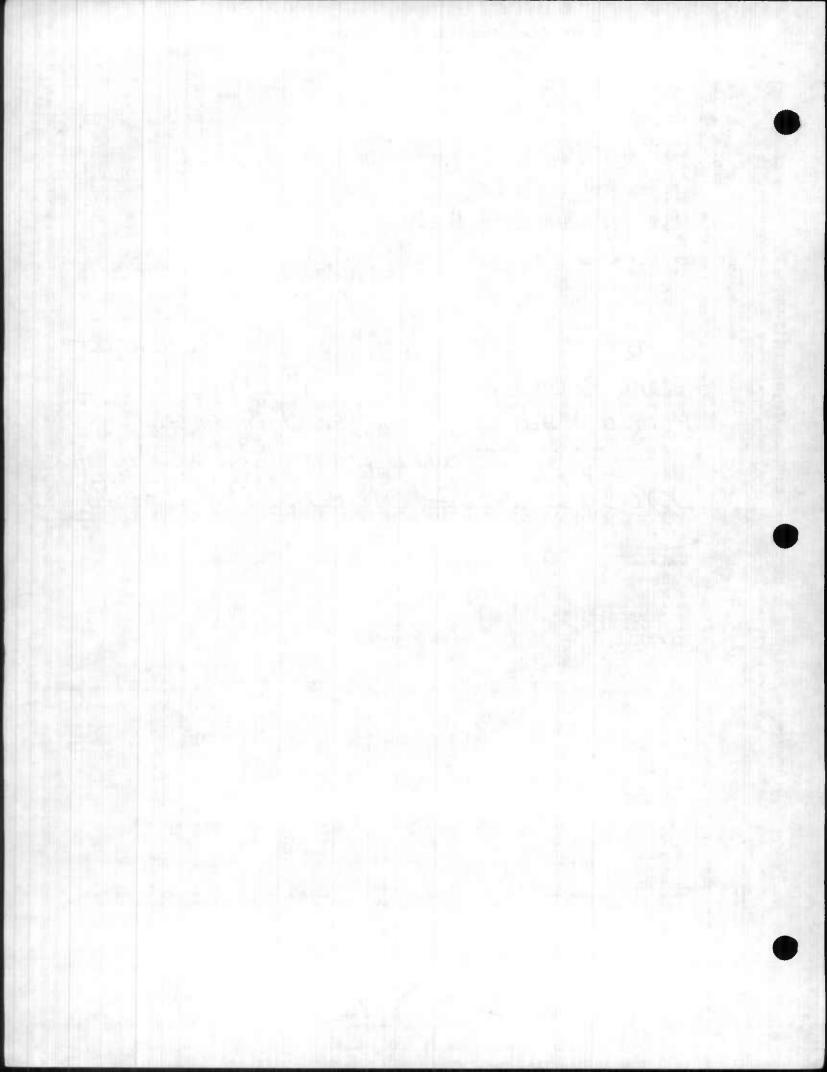
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miner	48 Facility Name (If not institution, given FRANKLIN SQUAR	1	CENTER	ROSEDI	Location of Death	-	of Death TMORE
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by Funeral Director	2 FORGOHEM (1.	10f. 2	21234		10g. Citizen of V	What Country?
nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J,S. 13. Was Dec If Yes, s	edent of Hispanic Origin? (becify Cuban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Rac Blac	e - Amaricen Indian, ck, White, etc.
	1 Nevar Married 2 Married 3 Widowed 4 Divorced	1 Tyes 2 No If Yas, Give Year or Datas:	1 □ Yes	2 No Specify:		Specify	"White
Be Completed	15. Decedent's E (Specify only highast gro	ducation ada completed)	16a. Decedant's Us (Give kind of	sual Occupation work done during most of we use retired)	orking	16b. Kind of Bi	usiness/Industry
d E	Elementary/Secondary (0-12)	College (1-4or 5+)	Chal	use retired)		Restau	reant
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ToB	FRANK C. C	s'hle:		mas	W/80		
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To Be Comp	Makylee O'A	leil	2 FORG	otten Ct.	Baltu	noce.	Md 21234
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	4 □ Donation 5 □ Other (Special	וע	ardens of	Faith	2000	ROSLO	ale, Md
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BeC	25. Was case referred to medical			26. Place of De	eath (Check only o		
ToE	examiner? 1 ☐ Yes 2 ◯ No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5□ Resi	denca 6 Oth	er (Specify)
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catio	2 Accident investigatio		М	1 ☐ Yes 2 ☐ No			
edical Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of fnjury - At h building, etc. (Speci	nome, farm, street, fact ify)	ory, office	28f. Location (- City or To		ber or Rural Route Number,
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	one)	and manner stated.			urred at the time,		
Σ	29b. Signature and title of certifiar		_	29c. Licanse number			d (Month, Day, Year)
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	30. Nama and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	- 20:15 7		Mr.	24
	STUART WILLES, MD.			E DRIVE, BAL	TIMORE	170 212	757
State	31. Date filed (Month, Day, Year)	32. Régistrar's Sign	atura B	1			



00-5283-510 Donald Pennington mnn

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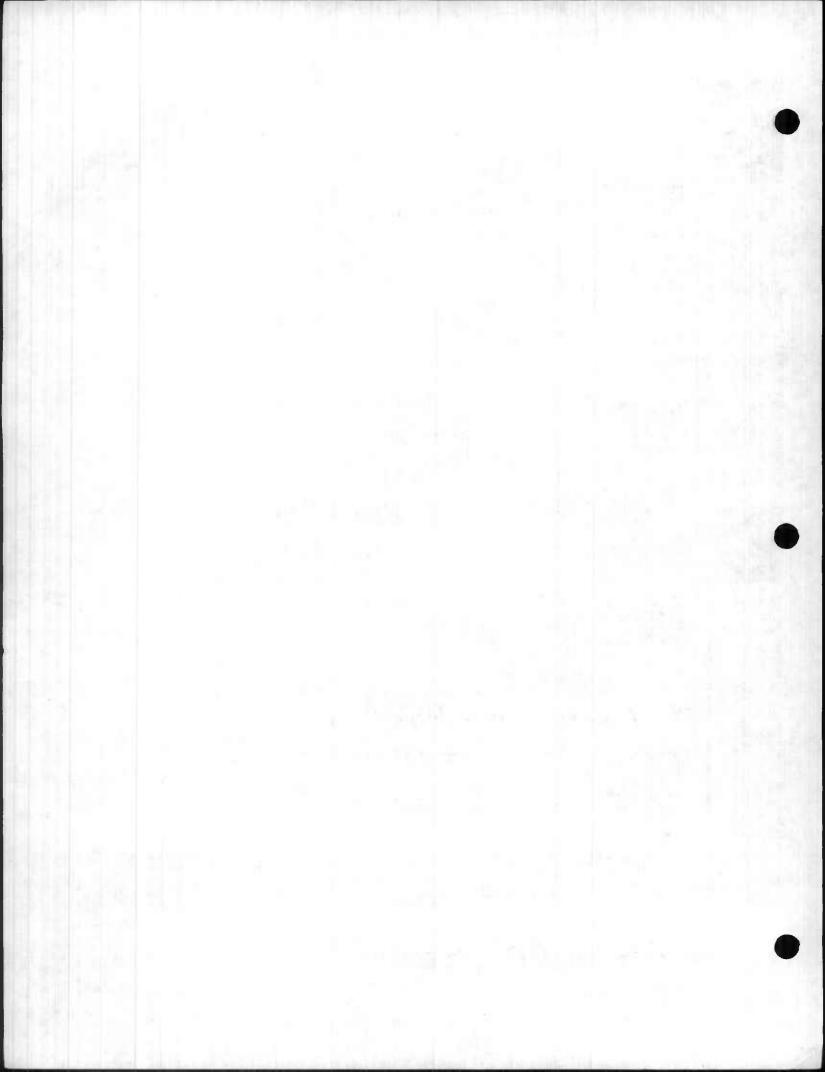
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020	urs after death v aff, or heme 23s Examiner main	44	11. Marital Status1 Never Marri3 Widowed		12. Wes De Armed I d 1 Tyes If Yes, C Year or	cedent Ever In L Forces? unla : 2 No Give Dates:		Vas Decedent of Yes, specify Cu			pecify Yes or No- Pican, etc.) 14. Race - American Black, White, etc. Specify: black		c.		
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lany	and N		19a. Informant's Ne	eme/Reletionship	(Type, Print)		19b. Mailir	g Address (Stree	et and Numb	er or Rura	l Route Numb	er, City or Town	n, State, Zip C	ode)	
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Baltimore,	Pages 1 nent of H int: If fler iny or oth	2			□Removal from		Place of Dispo cemetery, cren	sition (Name of natory or other pl	aca)		Dete	20c. Location	- City or Tow	n, State	
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State Registrar

THE mont M. King 31. Date filed (Month, Day, Year)

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. ASP State of Maryland / Department of Health and Mental Hygiene 32394 00-5388-510 Certificate of Death JOHN PERRY 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death Month Day SEPTEMBER **Physician** JOHN PERRY 23 2000 11:00 A /Medical 4a Facility Name (If not Institution, give street and number)
1812 W. PRATT ST. 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE | Under 1 Yaar | Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Unk | 9. Birthplaca (State or Foreign Country) Unk 5. Social Security Number UNK 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Months Days 18 M 2□ F Yrs. unk Director Usuat Rasidence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Nerns 23s or 28s-f show treumatic event, the Medical Examiner must be notified at MD Baltimore 1X Yes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizan of What Country? 1812 W. Pratt Street 21223 USA Funerai filed within 72 hours efter death 14. Race - American Indian, Black, White, etc. 11. Marital Status unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Evar in U.S. Armed Forces? Un K 1 Yes 2 No If Yes, Give Yaar or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yas 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education
(Specify only highest grade completed)

UNK
College (1-4or 5+) Be Completed 16a. Decedant's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry unk el Hygiene. Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middla, Maiden Surname) Pages 1 and 2 should be next of Health and Mentel ie marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) O.C.M.E. nt of Health a 111 Penn Street Baltimore, MD 21201 20b. Placa of Disposition (Name of cemetery, crematory or othar place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☒ Other (Specify) in State ò Department Important: It any Injury or 2005 in state 21. Signature of Funeral Service Licenses Wade, Pirector 32 Nama and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical CAVOICYARUL **Examiner** Due to (or as a consequenca of): Physician/Medical Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last usa as the buriel-tran Due to (or as a consequence of) and Box 68760. ate has been signed by the attending physician page 2 should be detached for usa as the buria Due to (or as a consequence of): P.O. Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 24a. Was an autopsy performed? 2□No

Division of Vital Records, To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or Attending Physician: after death. To the Hospital within 24 hours a To the Funerel D

23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? Yes 2 No 25. Was case raferred to medical examinar? 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 1☐Yes 2☐ No 28a. Data of Injury (Month, Day Year) 27. Manper of Death 28d. Dascribe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. Licanse number

O.C.M.E

sarks

State Registrar

Medical Certification: To

30. Name and addrass of persort JACK W.

31. Date filed (Month, Day, Year)

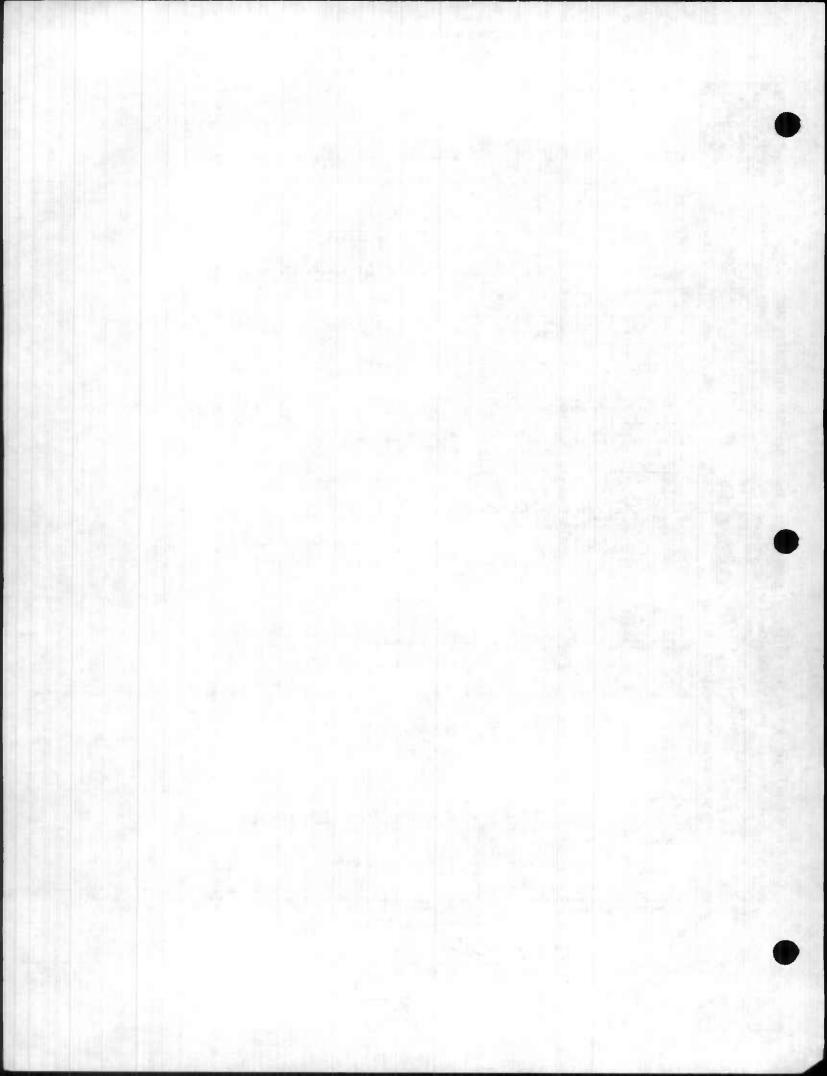
13

2000

who completed causa of death (Itam 23a) (Type, Print) MID 32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

SEPTEMBER 24,2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** lo Roth. e (erson OCTOBER 2000 7:28am /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 8. Data of Birth (Month, Day, Year) Nov. 26, 1909 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Hours 1 M 2 F MĎ 216-05-6778 Director 90 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. inside City Limits 28a-f show must be notified at N/A Director 1 Yas 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 238 700 West 40th Street 21211 U.S.A. Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 11. Marital Status traumatic event, the Medical Examiner 1 Yes 2 No if Yes, Give Yaar or Dates: 1 □ Nevar Married 2 □ Marriad 1 ☐ Yes 2 No Specify: by White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education 16b. Kind of Business/Industry marked other than Eiamentary/Secondary (0-12) College (1-4or 5+) Dietary worker Hospital terson, 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Louis J. Nagle Teresa Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health at It It Item 27 Is George W. McManus- attorney 3703 Greenway, Baltimore, MD 21218 or other altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Department Comportant: If Hilltop Service Corporation 10/16/00 any Injury Towson, MD 21. Signature of Funeral Service Lice 22. Name and Address of Fecility William G. Dau Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest shock, or heart failure. List only one cause on each line. Intervel Between Onset end Death Physician /Medical Immediete Ceuse (Final disaasa or condition rasulting in deeth) Examiner Examiner certificata be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Box 68760, IAL Physician/Medical USB BS The law requires that the death P.O. Part II. Other eignificant conditions contributing to death but not rasulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probabiy 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of causa of deeth? page 2 should Completed 24e. Wes an eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificata Division of Vital Attanding Physician: Be 25. Wes case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA funeral Date of injury (Month, Day Year) 28c. injury at Work? Certification: 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Naturei 1 Yes 2 No death 2 Accident after deat filled in by the 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete and piace, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and menner stated. Medical 29e. Certifier (Check only one)

29c. Licansa number

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6701 N. Charles st.

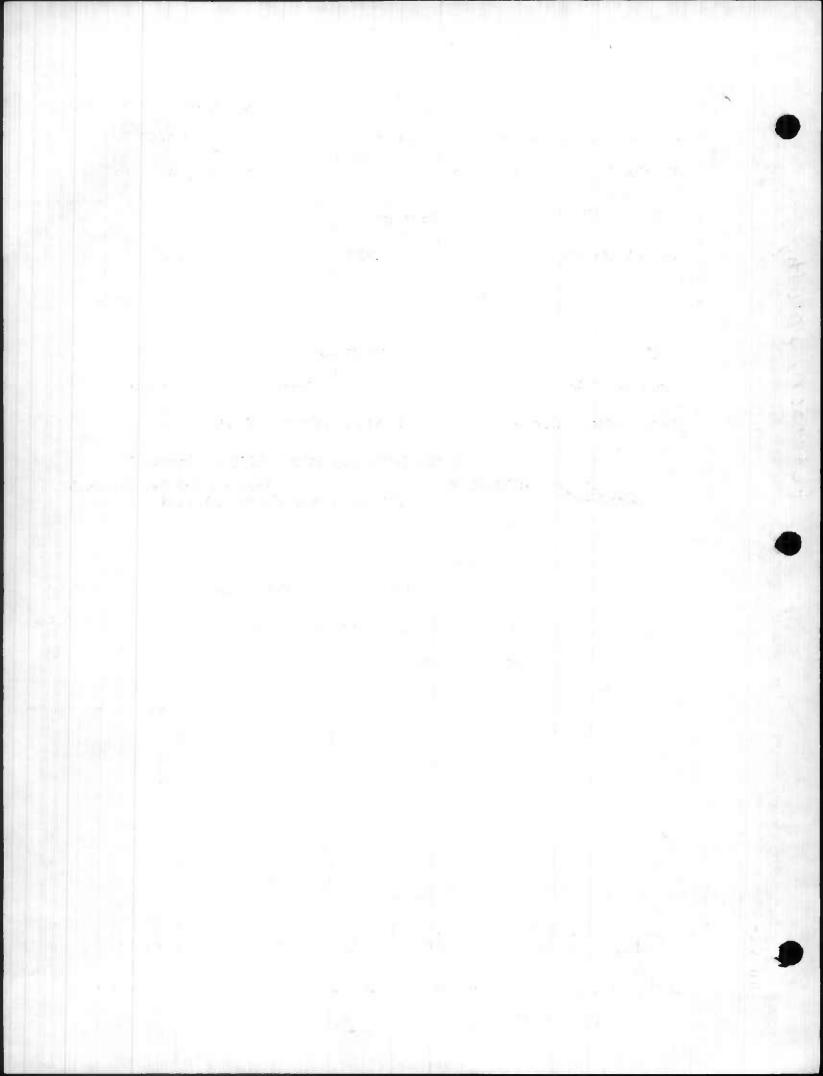
32. Registrer's Signeture

29d. Data signed (Month, Day, Year)

State Registrar 29b. Signeture and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (item 23a) (Type, Print)



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	1. Decedent's Name (First, Middle, Last)											Time of Death	
ician dical	CHARLES FRANKLIN PARKS								Month OCTOBE	OCTOBER 09 2000 0705			
niner	4h City Town or Location of Death 4o Country of Death									of Death			
	WASHINGTON COUNTY HOSPITAL						IAGERS			WASHI			
al 💮	5. Social Security Number 6. Sex 7. Aga (In yrs			Months Days Hours Min.				Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (Si Country)		(State or Foreign		
or	232-90-3328			46 Yrs.					9/16/1954 WEST			RGINIA	
	Usuat Residence of Decedent 10a. State 10b. County	. Town or Lo	cation					TVC .	10d. le	nside City Limits			
5											□Yas 20XNo		
20	10e. Streef and Number	DB I	MARTINSBURG 10f. Zip Code				16			10a Citizen of I	0g. Citizan of What Country?		
5	220 PINE COURT					25401				USA	mat country.		
era								iain? (Sna	city Vac or No				
by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Ford	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexicen, Puerto								
8	15. Decedent's				16a. Decedent's Usual Occupation					16b. Kind of B	6b. Kind of Business/Industry		
Be Completed	(Specify only highast) Elementery/Secondery (0-12)		College (1-4or 5+)		(Give kind of work done during most of work life. DO NOT use retired)				mg				
E	12	4	3, 37,	LAB TECHNICIAN					RUST-OLEUM COR			RP.	
3e C	17. Father's Neme (First, Middle, Last)								ne (First, Middle, Maiden Sumame)				
ToB	CHARLES RAY	MOND PARK	ND PARKS			BERNICI			E ELIZABETH GRANTHAM				
-	19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num						and Numb	er or Rura	or Rural Route Number, City or Town, State, Zip Code)				
4	CHARLES RAYMON	D PARKS /	FATHER	20	6 JOH	INSON	N ST.	, MAF	RTINSBU	RG, WV	25401		
	20a. Method of Disposition 1 Description 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donelton 5 Other (Specify) 20c. Location - City or Town, State 10/14/00 MARTINSBURG, WV												
pace.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility												
DUC	BROWN FUNERAL HOME, 327 W. KING ST.,												
	PO BOX 821, MARTINSBURG, WV 25402 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate										proximate		
ın 📗	shock, or heert failure. List only one cause on each line. Immediate Cause (Final DTC/FED VIEWFDTC/FIN AD DS/CDV ACTA										Interval Between Onset and Death		
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r	disease or condition resulting in death) RIGHT VENTRUCTAR DYSPLASTA Due to (or es a consequence of):												
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dical Examiner	Sequentially list conditions. Due to (or as a consequence of):												
EX	Sequanfially list conditions, if any, leading to immediate ceuse. Enter Undarkying Cause (Disease or injury c.												
Ica	Cause (Disease or injury that initiated events passing in death) Last Dua to (or as a consequence of):												
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sick	Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.								23b. Did tobacco use contributs to the cause of death?				
y Phy								1 Yes 2 No 3 Probably 4 Unknown					
Completed by Physician/Me								performed?		availab	utopsy findings ie prior to ition of cause h?		
Eo								12	Yes 2 No	12/40	5 2□ No		
Bec	5. Was cese referred to medical							e of Death	of Death (Check only one)				
To B	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home										her (Specity)		
=	27. Menner of Death	28a. Date of	f Injury	28b. Time of 28c. Injury at						how injury occur			
atio	1 XX atural 5 Pending investigation		(Month, Dey Year) injury Work? 1 □ Yas 2 [] No					
entifica	3 Suicide 6 Could no determine	28e. Place of building	me, farm, st	e, farm, street, factory, office			28f. Location (Street and Number of City or Town, State)			ber or Rural Ro	ute Number,		
Mining a nous and open. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
ğ	29b. Signature and title of certifier 29c. License number							29d. Data signed (Month, Day, Year)					
Medic	29b. Signature and title of certifier				290	c. Licans	e number			29d. Data signe	ed (Month, Day,	Year)	
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31. Date filed (Month, Day, Year)

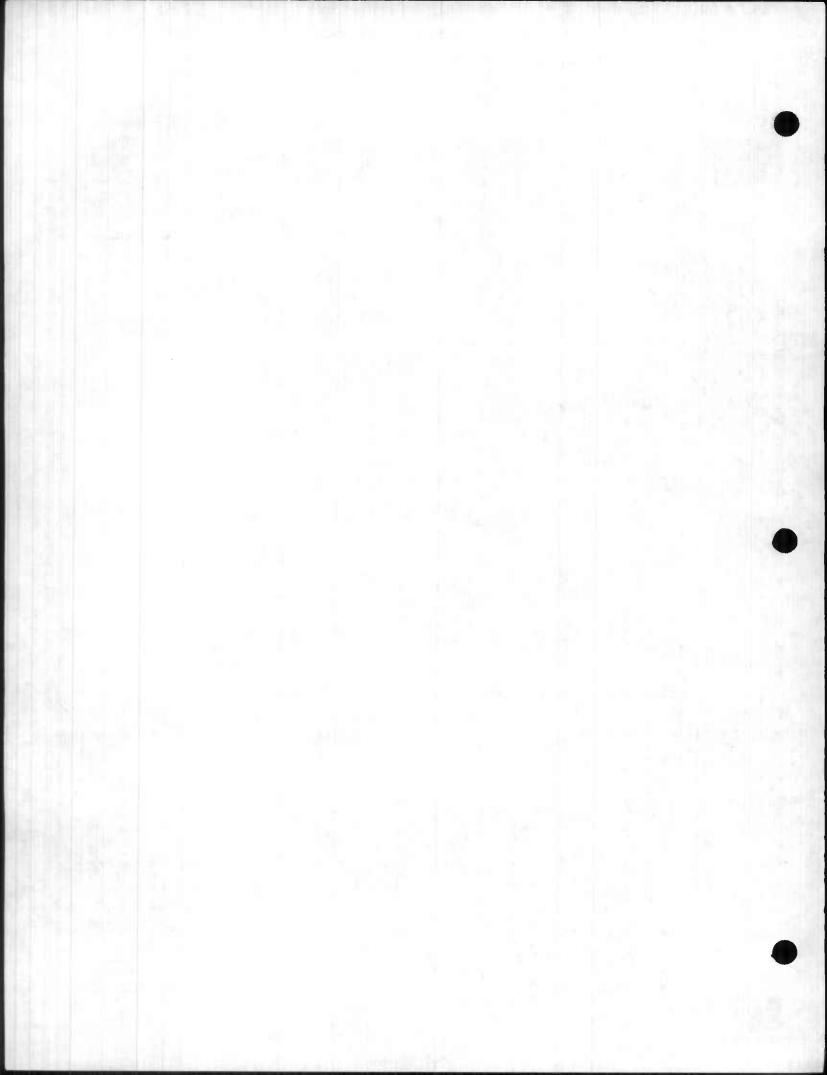
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DHMH 16 Rev 6/95

ORIGINAL

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 1 per phy, 788, 10/13/00dhb Certificate of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death **Physician** Fanny B. Pusinsky 1403 GUILITÉ tasirosta 05 2000 10 /Medical Facility Name (If not institution, giva street and number 4b. City, Town, ec Location of Death 4c. County of Death Examiner Ballining Med If Undar 24 Hrs. Birthplace (State or Foreign Country) **Funera** Days Hours Min. 34 309399 1 M 2 T 5/19/23 Director West Virginia Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f short Baltimore MD 1 HYES 2 No Director iene. Than "natural", or items 23s or 28s-f the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21223 A/CU Funeral filed within 72 hours after death 14. Raca - American Indian, Black, White, etc. Was Decedent Ex Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 20 No If Yes, Give Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middla, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental ant: if Hem 27 is marked o is marked (unobtainable) Libby Burns Napier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Libby Pusinsky-Daughter 119 Glider Drive Middle River, MD 21220 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Washington Cr. 10-11-00Laurel, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home 7250 Washington Blvd. Elkridge, Maryland 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Fibillehor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the buriel-tran The law requires that the death certificate be execut Box 68760. Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should Be Completed hes 1 Yes 213 No 1 Yes 20 No certificate al or Attending Physician: The safer death.

It Director: After this certificate of in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28c. injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 [Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Sulcida 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatura and title of certifier 30. Name and add sss of person who completed cause of death (Item 23a) (Type, Print) MIV. BAltimone

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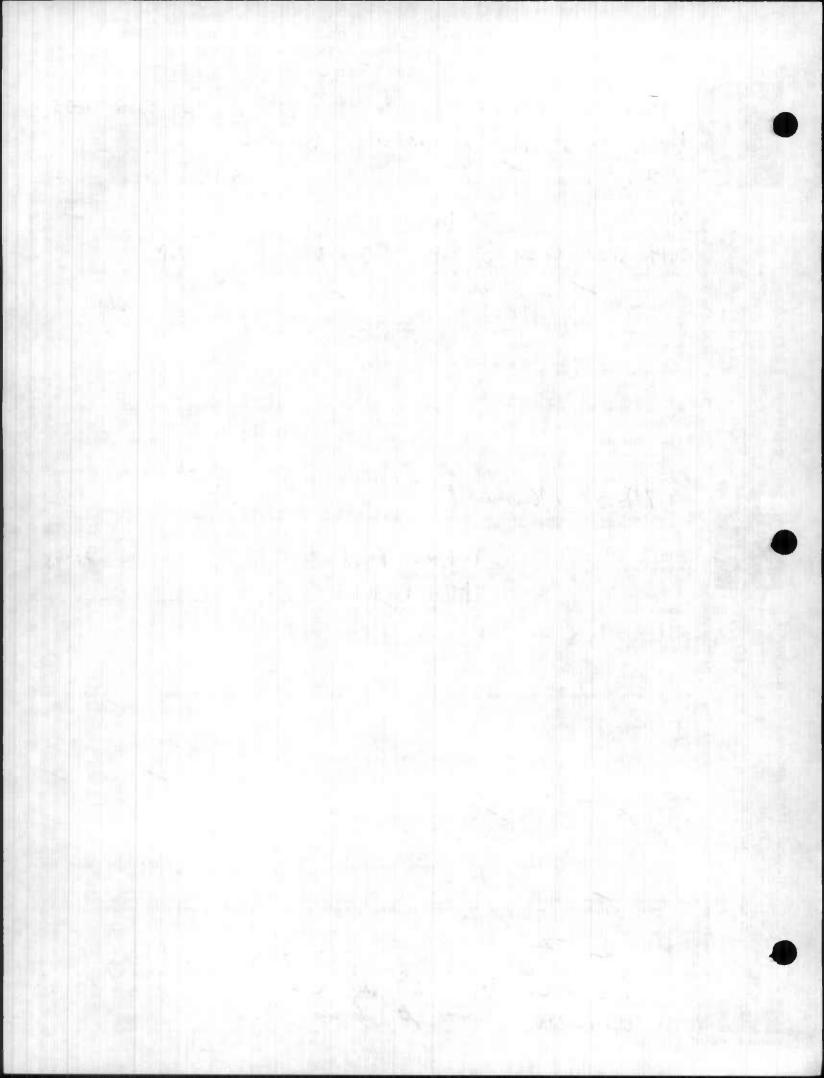
Registrar

31. Data filed (Month, Day, Year)

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32. Registrar's Signature

Depende



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death 945 **Physician** ATHERINA VATRO 10 2000 HM /Medical 4a Facility Nama (If not Institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE, MD BALTIMORE DAMARITAN LOSGITAL 5. Social Security Number If Undar 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) Sex 1□M 2□F **Funeral** Months Days Hours Yrs. 217-12-7915 Director 07/30/1924 MD Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show N/A Baltimore 1 XYas 2 No Director 10e. Sfreet and Number 10f. Zio Coda 10g. Citizan of What Country? 6 2219 Fleet Street "natural", or items 23a 21224 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Dacedent of Hispanic Origin? (Spacify Yas or No If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 72 hours after 1 Nevar Married 2 Married 1 Yas 2 No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Caucasian à Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Hygiena. 9 Elamantary/Secondary (0-12) College (1-4or 5+) Homemaker Home Pages 1 and 2 should be filed nant of Health and Mental Hyginht: If Item 27 Is merked other 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Henry Coyne Katie Weber 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2: Department of Health as Important: If Item 27 Is any Injury or other trace Mr. Edward Patro 4905 Tartan Hill Road, Baltimore, MD 21128 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Other (Specify) Entombment St. Stanislaus 10/11/00 Baltimore, MD 21. Signature of Funaral Sarvice Licenses 22. Nama end Address of Facility
Kaczorowski Funeral Home, P.A. 23a. Part 1. Entar tha disaase, or complications that caused the death. Do not antar the mode of dying, auch as cardiac or respiratory arrast, shock, or heart tailure. List only one cause on each line. Approximate Interval Batween Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical (ARDIO PULMONARY Examiner 140 CARDIAZ Examiner Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury and physician a 68760 Physician/Medical that initiated events rasulting in death) Last Dua to (or as a consequanca of) 88 Box P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the 1 Yes 2 No 3 Probably 4 Unknown signed by EPSIS Records, þ 9 24b. Ware autopsy findings availabla prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 PNo 1 ☐ Yas 2 ☐ No 1 Yas of Vital Be 25. Was casa refarred to medical 26. Placa of Death (Check only one) Hospital: Othar: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 10 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 1 De Natural 28c. Injury at Work? 28d. Dascribe how injury occurred Medical Certification: i or Attending P after death. Director: After Division 5 Panding invastigation 1 Yas 2 No 2 Accident 6 Could not be 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide To the Hospital of wilhin 24 hours a To the Funeral D 29a. Certifier 112 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date and place, and dua to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 290. Signature and title of ophilis 29c. Licanse number 29d. Date signed/[Month: Day, Year) 100 of death (Itam 23a) (Type, Print) KAVEN

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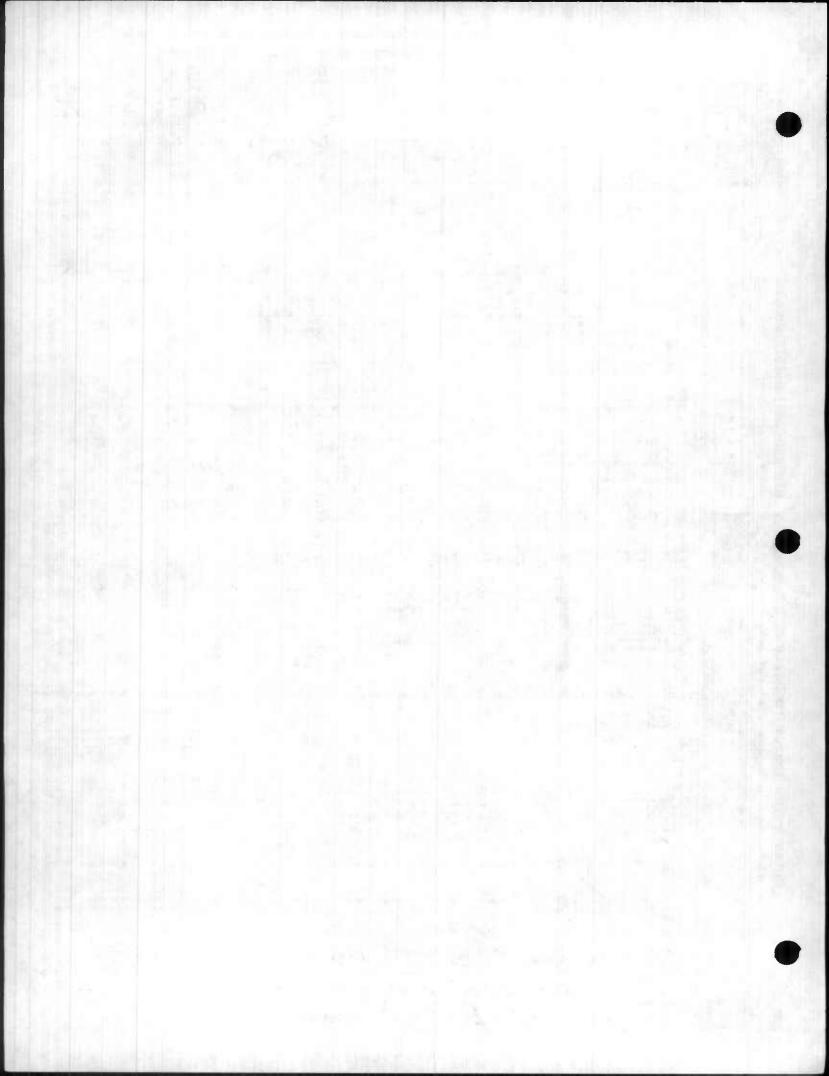
Registrar

Date filed (Month, Day, Year)

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32. Registrar's Signetura

Geneva



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 2000 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7. Age (In yrs. last birthday) | If Under 1 Yes | Months | Day 5. Social Security Number 6. Sex 110 M 2□ F 410 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 218-72-8216 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTO 1 Yes 2 No EDGEMERE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21272 USA 2840 LODGE FARM 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Status 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 Yes 2 No Specify. Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BRICKLAYER CONSTRUCTION NONE 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 6-LORIA KoberTS WILBUR ANN WALLACE 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 2840 LODGE FARM RS. EDGEMERE, MD GLORIA ANN KobeRTS 20a. Method of Disposition 20b. Plece of Disposition (Name of Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility DELCHOOKE 21. Signature of Funeral Service Licenses FUNERAL Heme 322 S. HiGA ST 10 2/202 e. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest that only one cause on each line. Approximete Intervel Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) Veytropinia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evalleble prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Impatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be assocuted

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Funeral

Director

8

Hygiene.

Pages 1 and 2 should be nent of Health and Mental

if them 27 is or other train

Department of Important: If any injury or

21215-0020

Baltimore, Maryland

P.O. Box 68760,

Division of Vital Records,

certificate this the

Physician/Medical Examiner þ Completed Be Certification: To

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely

filled in by

State Registrar

Medical

27. Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signeture end title of certifier

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29c. License number

28c. Injury at Work?

1 Yes 2 No

29d. Date signed (Month, Dey, Year) Kes- 2001

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Intern 30. Neme and ildress of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be

4940 Gastern Averue

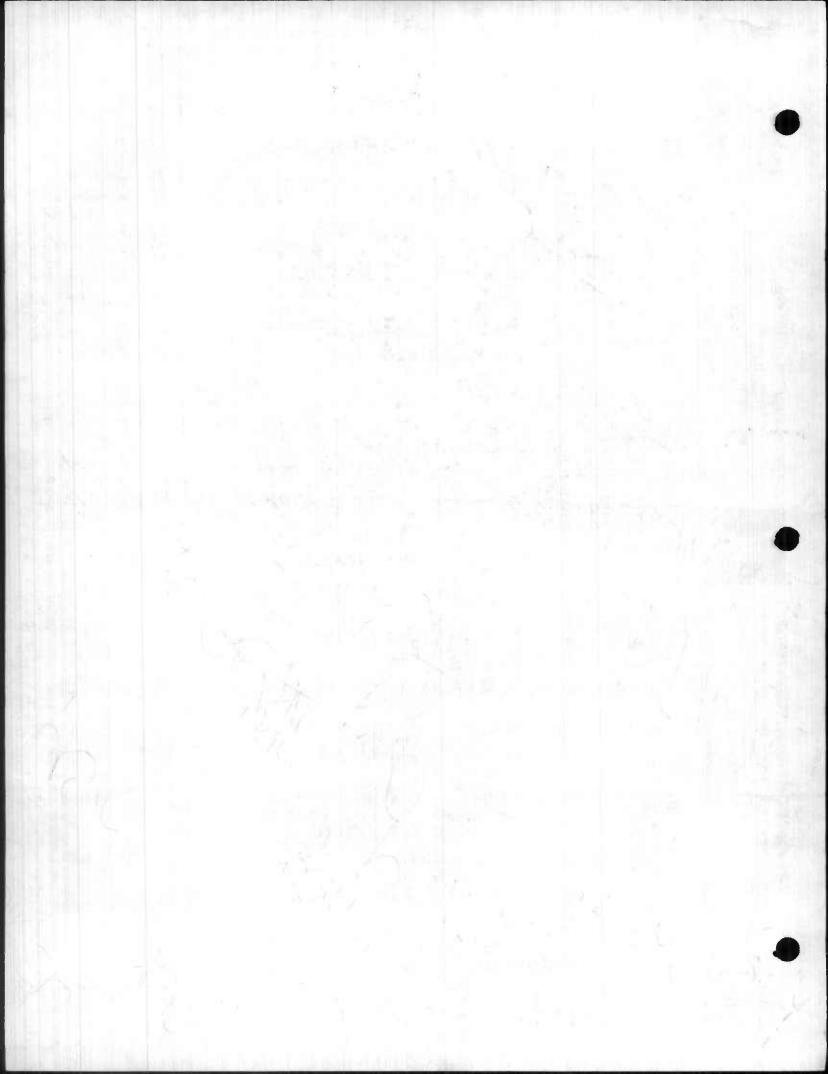
Haltimore,

Braudes 31. Nate filed (Month, Day, Year) 32. Registretis Signeture

28a. Dete of Injury (Month, Day Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

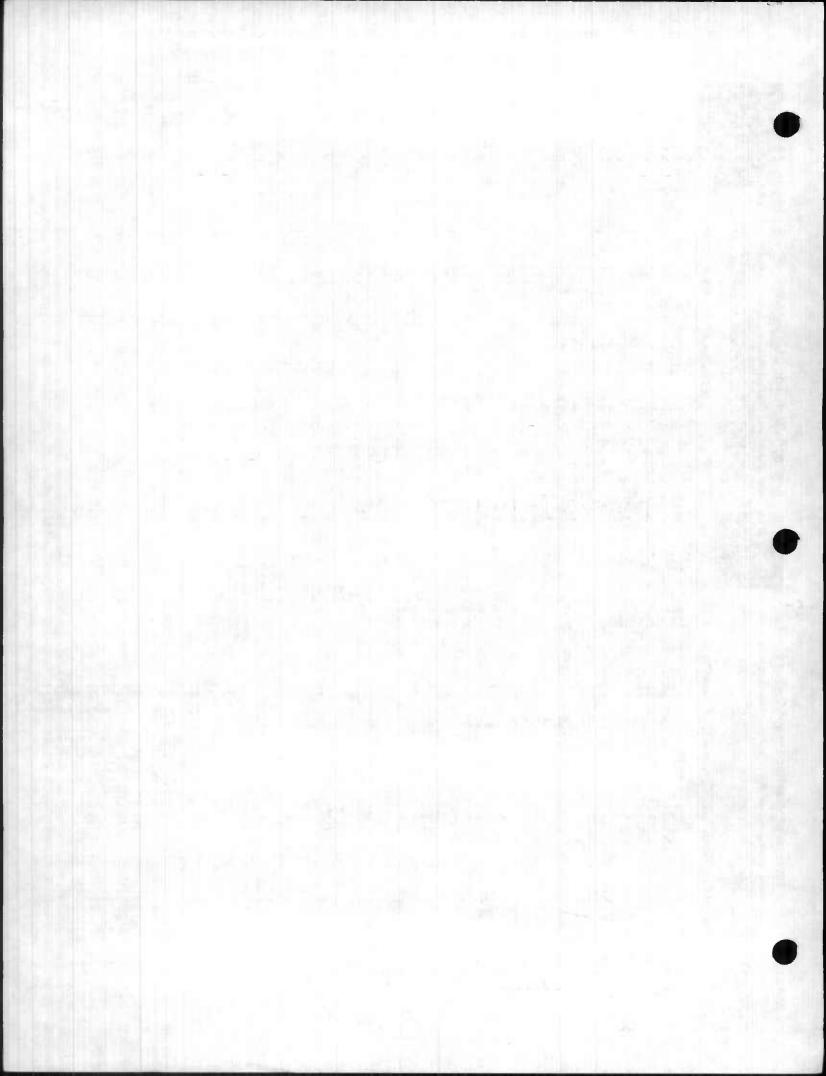


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certificate	of D	eath	,	Reg. No.	3	2400
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Examine	de Casilla Mana //finet lastitudes als	e street end number)				City, Town, or Loc	ation of Death	4c. County	of Death	
2-2	Bon SEcours	Wos Pital					ore			
Funeral Director	5. Social Security Number 6. S 220–18–6376	Sex 7. Age	(In yrs. lest b	Yrs. If Under 1 Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey 7-16-	1919	9. Birthpled Country	N.C.
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ahow		16-0-0							100	Y□ Yes 2□ No
(fer death with the Maryland referre 23s or 28s-f show there must be notified at	Md N/A		Balti							****
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ath w	3913 Carroway Av	enue		212				US		
ter des Items	11. Mental Status	12. Wes Decedent E Armed Forces?	iver in U,S.	13. Was Decede	ent of Hisp ify Cuben,	panic Origin? (Spe Mexican, Puerto F	cify Yes or No- tican, etc.)	14. Rec	e - American k, White, etc	
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ind 21215-002 be filed within 72 hours tal Hygiena. d other than "natural; event, the Medical Ex-	15. Decedent's Ed (Specify only highest gre	ducation	16	a. Decedent's Usuel	l Occupati	on ring most of workin	a	16b. Kind of Bu	siness/Indu	stry
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M alth 227 lt.	James R. Smith, S	r - Son		5709 Rock	spri	ng Road	Balto.	Md	21209	
Nore, Maryland in the lies of Health and Mental Hyg it from 27 is marked other or other treumatic event.	20a. Method of Disposition		20b. Placa	of Disposition (Namery, cremetory or off	e of		Dete	20c. Location -	City or Towr	n, State
7 2 9 2	1X Burlal 2 Cremation 3 4 Donation 5 Other (Specif	y) /	Arbu	tus Memor	ial	Park 10-	14-00	Arbutu	s, Md	
Baltirr permit. Pa Departmen Important: any injury	21. Signature of Funeral Service Licer	F Jana	Cono		F/H	West	o Pal	timono	M - 01	215
	23a Part I Enter the disease, or com or heert failure. List only	plications that caused	the death. Do	not enter the mode	of dying,	ash Avenu	respiratory er	rest,	; A	pproximete
Physician	or heert failure. List only	one cause on each	θ.							nterval Between Inset and Death
/Medical	Immediate Cause (Final	+	11.	BrEast	Lr.	10 000			-	
Examiner	Immediate Couse (Finel disease of condition resulting in death)				CAI	ricer	A			- gear
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cate be assecuted physician and a the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or es a	consequence of):						
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the life		end menner stat	led.							
To the trop of the	29b. Signature end title of certifier	,			. License r			29d. Dete signe		
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4	30. Nema and address of person who	completed cause of de	eth (Item 23a) (Type, Print)				1.11	1	21223
O	MARCOS GA	LIZIA V	M.D.	BON	SEG	cours for	05 p.ta,	Baltin	NE, M	21223
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DHMH 16 Rev 6/95



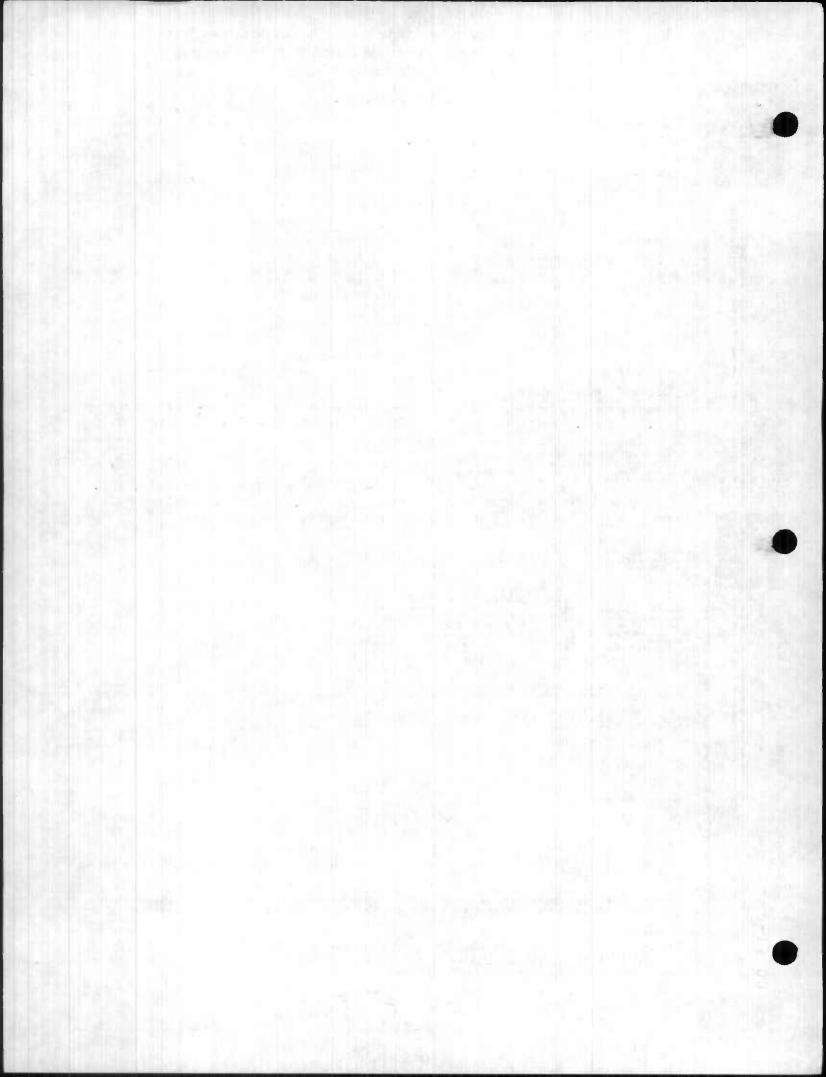
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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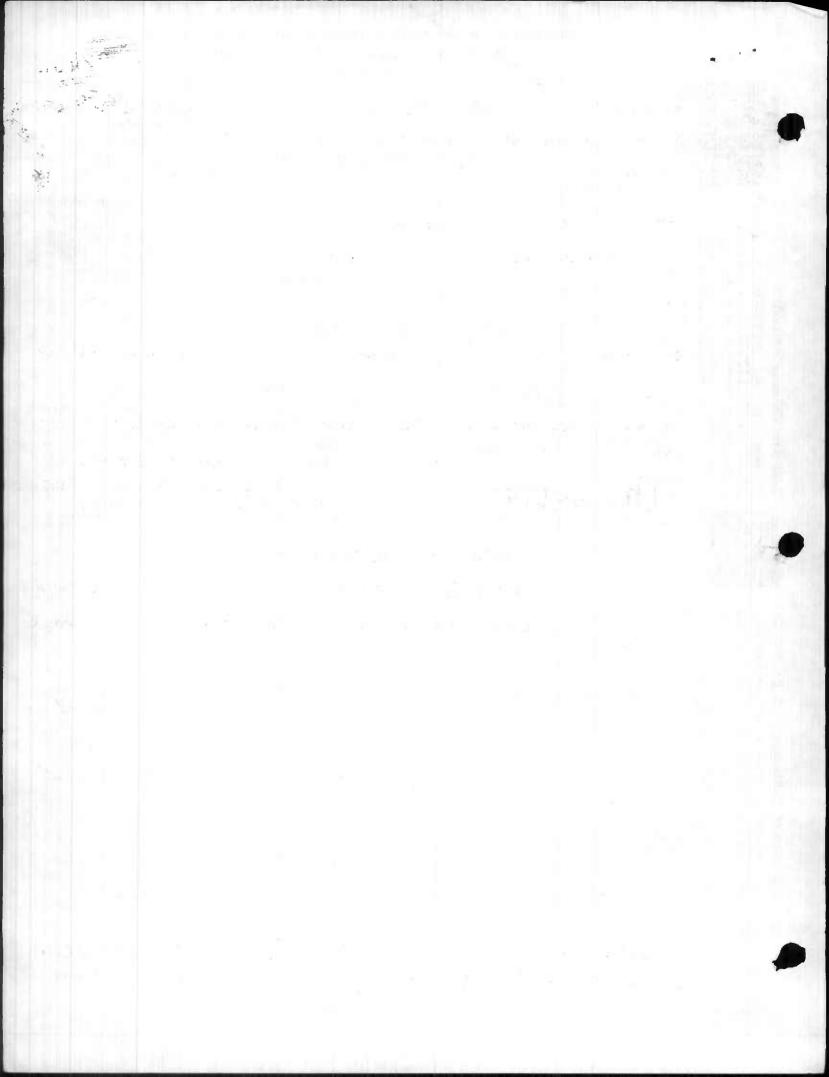
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6	Physician /Medical	Decedent's Neme (First, Mide	dle, Last) Alfr	ed San	ntanoce	eta, Sr.	MALE	2. Dete of D Month Octobe	Dey	Yeer	3. Time of Death 11:58 AM
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		Johns Hopkins	-				Baltimor	-		N/F	
	Funeral	5. Social Security Number	6. Sex 1 → M 2 □ F	7. Age (In yrs. k	est birthday) Yrs.	If Under 1 Yeer Months Deys		lin. (Month, D			ce (State or Foreign
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fano	Bu .	10a. State 10b. Count	ly	10c. City	, Town or Loc	cation				10d	I. Inside City Limits
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1	or 28a-t a be notified Director	10e. Street and Number		I Harris		10f. Zip Code			10g. Citizen of	What Country	n
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Maryland 21215-0020	by by	1 Never Merried 2 Me 3 Widowed 4 Divorce	If Yes. G		1	☐ Yes 2 🛣 No	Specify:		Specif	y. Whi	ite
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ary	marria M	19e. informant's Name/Relation		(Wife)	19b. Mailin	g Address (Street		Rural Route Num		, Stete, Zip Ci	ode)
	27.0	Mrs. Marie B.	Santanoc	eta	3219	McShane	Way Du	undalk, M	laryland	21222	
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60,		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events	SE	PS15							
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ita	entifica ector, Be	25. Wes case referred to medic examiner?	al		1		26. Plece of	Deeth (Check only	one)		
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Sio	at Director. Aller in by the funeral Certification:	2 Accident inves	tigetion				Yes 2 No	00/ 1	(0)		2 - 1 - 1/ - 1 - 1
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	6	30. Name and address of person	n who completed cau	use of deeth (Item	23e) (Type, f	rint)	100		-	100	
	0	annder is	Julin 7	2 Mari	rel-	Slora.	Batti	nich	MD.	21221	/
EST	State	31 Dete filed (Month, Day, Yea,	3 2000 32.1	Registrar's Signet	ure /	In	430				



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State of Maryland / Department of Health and Mental Hygiene

Physician					Cen	tificate of			g. No.	0117011			
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	4	5. Social Security Number	6. Sex 7.			If Under 1 Year	District		N				
Funeral Director		212-30-3530 Usuel Residence of Decedent	1□ M 2□ F	66	lest birthday) Yrs.	Months Deys	Hours Min.	Date of Birth (Month, Day, 1) 1-26-	(ear) 34	9. Birthplece (State or Foreig Country) VA			
tet		10a. State 10b. County		10c. Cit	y, Town or Loc	ation				10d. Inside City Limit			
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or 20	5	10e. Street end Number				10f. Zlp Code		10	g. Citizen of Wh	net Country?			
230	9	1805 Burnwood	Road			21239			USA				
iene. than "natural", or itema 23a or 28a-f show tha Medical Evanthet must be notified at ompleted by Funeral Director	2	11. Marital Status 1 □ Never Married 2 □ Marrie 38 □ Widowed 4 □ Divorced	12. Wes Deceder Armed Forces ad 1 Tyes 2/C If Yes, Give Yeer or Dates	s? M No		fes Decedent of H Yes, specify Cuba ☐ Yes 2 ☐ No	tispenic Origin? (Specif an, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)		Americen Indian, White, etc. Black			
ted ted	2	15. Decedent's	s Education		16a. Decede	ent's Usuel Occup	petion	10	6b. Kind of Busi	Iness/Industry			
Med or	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. D	O NOT use retired	during most of working d)						
	5	8th Grade	NA		Labo	rer			Constru	uction work			
# 5 8 m		17. Fether's Neme (First, Middle, L.	ast)				18. Mother's Name (F	First, Middle, Me	eiden Sumeme)			
	5	Robert	Saunde	rs			Clara		Benne	ett			
7 is marke traumatic		19e. Intorment's Name/Reletionshi	ip (Type, Print)		19b. Meiling	Address (Street	end Number or Flurel F	loute Number,	City or Town, S	tete, Zip Code) 2120			
		Kenneth L. Sa	aunders,	Sr.	4223	Stanwoo	od Avenue	Balt	imore	, Maryland			
Logostament of hear important: If item 2 any Injury or other 2 and Injury or other 2		20e. Method ot Disposition			Plece of Dispos	ition (Neme of etory or other ple	ce)	Dete 20	c. Location - C	Ity or Town, Stete			
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	3	2 ☐ Accident investige	etion			M 1□	Yes 2 □ No						
he fun	<i>i</i>	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Pieca of I	njury - At ho	ome, farm, stre	et, tactory, office	281	Location (Stre	et end Number Stete)	or Rural Route Number,			
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al Director: After ed in by the fun Certificatio		100	200		29a. Certifier (Check only 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date						due to the ceu	ise(s) end meni e end pleca, en	ner es steted.
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- T	3	one)	xaminer: On the basis	stated.					d. Dete slaned				
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Medical Certification	3	29b. Signeture and title of certifier	manner:	stated.					d. Dete signed of the control of the				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2403 Certificate of Death Amended Item#30 perDVRG788 10/13/2000 EW Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Year SURYANARAYANA 355 PM KALACHAR 10 10 2000 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death of A Maryland Hospital Baltimore Baltimore City 5. Social Security Number If Under 1 Year | If Under 24 Hra. Months | Deys | Hours | Min. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) 9. Birthpleca (Stete or Foreign Country) Deys 10M 20F 5 223-53-6748 08-11-1949 India Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 TYPE X NO Maryland Frederick Frederick 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 1800 Eagle Rock Lane 21702 States United 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indier 11. Meritel Status Bleck. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 1 ☐ Yes 2X No Specify: Specify: Asian 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Buainess/Industry 15. Decedent'a Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) Research Scientist Science Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) K. T. Kalachar Basavarajamma Kalachar 19e. Informent's Neme/Reletionship (Type, Print) Mani Alapat / Friend 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1800 Eagle Rock Lane Frederick, MD 21702 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Resthaven Crematory 10/11/00 Frederick, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of FacilitySkkot Cody, Licensed Mortician 44 Tremaine Ct. Baltimore, MD 21244 23e. Parx Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List on one cause on each line. Approximete Intervel Between Onset and Death Immediate Ceuse (Final Pulmonary diseese or condition resulting in deeth) Granulomatosis Wegener' Sequentietly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest bue to (or es e consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert It. Other elgnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Was en autopsy performed? 1 ☐ Yea 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 281. Location (Street end Number or Rural Route Number, City or Town, Stele) 3 Suicide 6 Could not be determined 28e. Pteca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

that the death certificate be executed physician and s the burial-trans Box 68760. 88 for use as ed by the a o م signed b Records, The law requires should I certificata has b Physician: director

After this funeral di

Physician

/Medical

Examiner

Directo

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the Maryland

I 2 should be filed within 72 hours after death with the Marylan h and Mental Hygiene. "I a marked other then "natural", or fleme 23a or 28e-f ahow "I a marked ovent, in Medical Exam or mark be notified a

traumatic avant,

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oths any Injury or other traumatic avant, pages.

Physician /Medical

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Certification:

edical

Baltimore, Maryland 21215-0036

Division of Vital or Attanding death. Diractor: after To the Hospital or within 24 hours aff To the Funeral Di completely filled in

State

Registrar

31. Dete filed (Month, Day, Year)

29b. Signeture end title of certifier

zebron K.

4 D Homicide

29a. Certifier (Check only one)

Marlin m

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 10-10-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

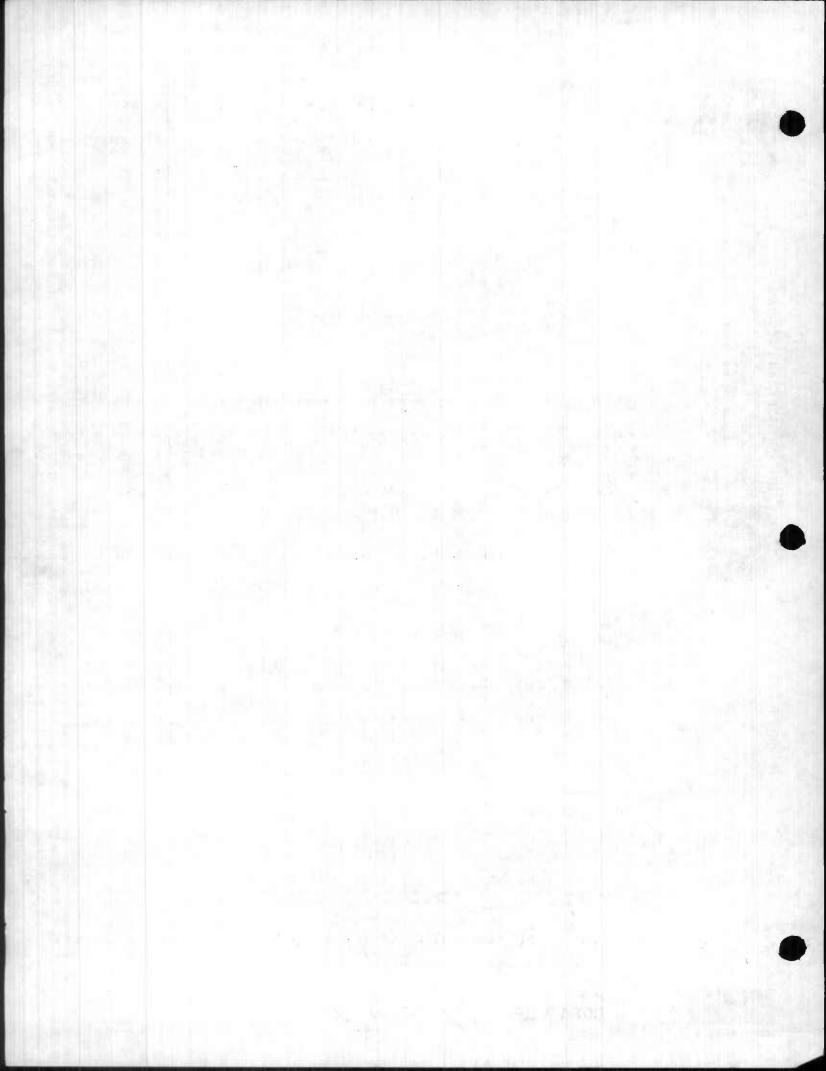
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32. Registrar's Signature Reperson parks

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Physician SANDERS SONDRA 2000 12.4581 9 /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner SECOUR HOSPITA DON 8. Dete of Birth (Month, Day, Year) NOV. 26, 1956 7. Age (In yrs. lest birthdey) 9. Birthplece (Stete or Foreign Country) MARY LAW 5. Social Security Number 6. Sex **Funeral** Months Deys Hours Min 1□M 28 F 218-60-6385 Director Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. fnside City Limits 28a-f ahow traumetic avent, the Medical Examiner must be notified at 1 Yes 2 No Director ANDALLSTOU SALTIMORE MARYLAND 10e. Street and Number 10g. Citizen of Whet Country? 6 382 238 ROFT USA. Funeral filed within 72 hours after death Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S Armed Forces? 11. Maritel Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 6 Maryland 21215-0020 1□ Yes 2KNo Specify: þ BLACK 3 Widowed 4 □ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) 12 HGRADE AUNDRO MAT other 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Pages 1 and 2 should be need of Haalth and Mental mert If Itam 27 is marked o ROWN NEWMAN KICHARD DOROTH 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Roule Number, City or Town, Stete, Zip Code) 3829 KICHARD BROWN ELM CROFT RANDALLSTOWN, MD21133 1-ATHER Baltimore, 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Burial 2 Cremetion 3 Removel from State CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) LANSDOWNE, MARYLAND 22. Name end Address of Facility BROWN JR. FUNERAL HOME any it JOSEPH 2140 N. H. BROWN FULTON AVE Williams 23a. Per II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory efrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician fmmediete Cause (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the deeth cartificate be assecuted usa as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Box 68760. P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No ρλ of Vital Records, after death.

Director: After this cartificate has been signed in by the funaral director, page 2 should t 24e. Wes en eutopsy performed? 24b. Were eutopsy tindings eveilable prior to completion of cause of deeth? Medical Certification: To Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case reterred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 1 Impatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 1 ☑ Netural Injury et Work? 28d. Describe how injury occurred 5 Pend ng investigation Division 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours at To the Funeral Di tortifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as steted.

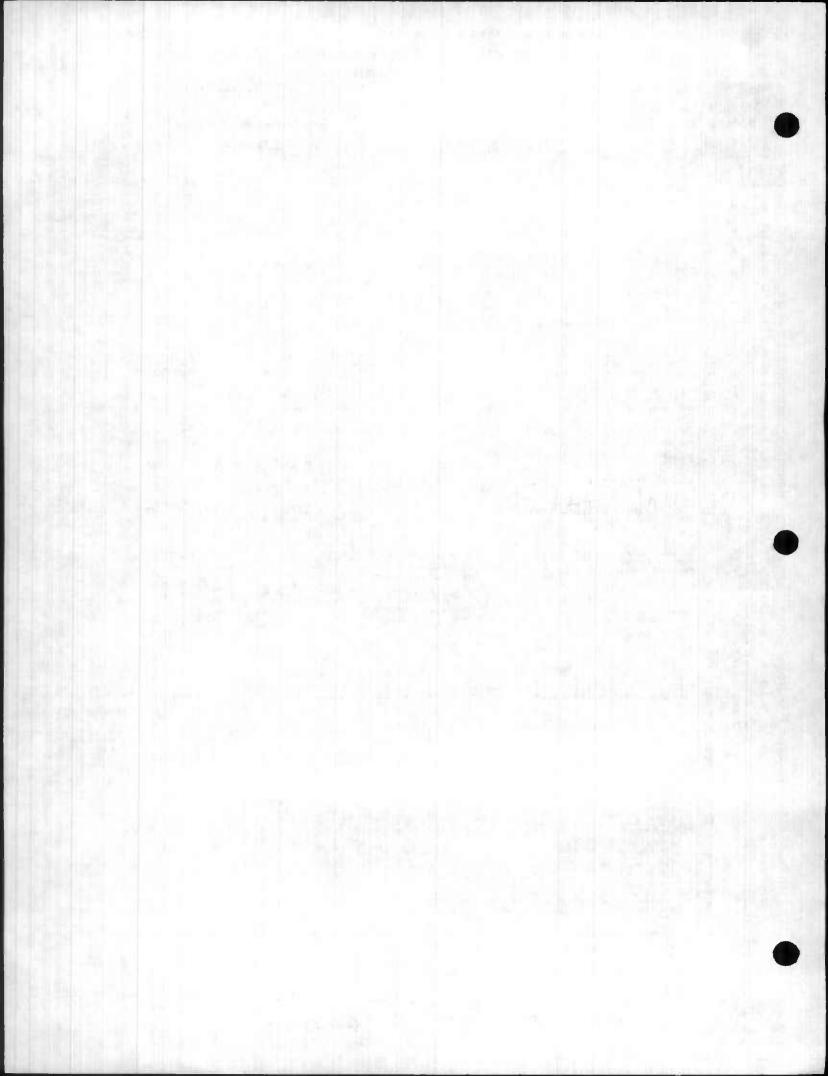
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end manner steted. 29e. Certifier compiataly 29b. Signature end title of certified 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) ANURADHA 1940 WBaltomble Screet Balt 940

DHMH 16 Rev 6/95

State Registrar 31. Dete tifed (Month, Day, Year)

3

32. Registrar's Signeture



Please Type or Print In Black Indelible ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Amend Item 1 per phy, 788, 1013/00dhb Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Angela Thieler Dev Year Month **Physician** 1220 00 06 /Medical Facility Neme (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner MARYLAND SALTIMORE MD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yea 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Deys 1□ M 2월 F Hours CALIFORNIA 1973 575-37-3386 27 JAN. 4, Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or literia 23s or 23e-f show the Medical Examiner must be notified at the Maryla 1 Was 2 No Directo MARYLAND BALTIMORE 10a. Street and Number 10f. Zio Coda 10g. Citizan of Whet Country? 3616 COOLIDGE AVE. 21229 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedant Evar in U.S. Armed Forces?
1 ☐ Yas 2 ☑ No
If Yes, Give Bleck, Whita, etc. 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiens. "n Elementery/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT ENVELOPE COMPANY Ith and Mental Hygie 27 is marked other i traumetic event, II 18. Mother's Name (First, Middle, Maiden Sumema) 17. Father's Neme (First, Middle, Last) should be and Mental RICHARD BURDESS BRENDALEE CLEMONDS 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, Stata, Zip Code) Department of Health and Capacitiment of Health and Important: If Item 27 is it any injury or other traum 2008. ROBERT LEE THIELER 3616 COOLIDGE AVE., BALTIMORE, MD 21229 20a, Method of Disposition 20b. Pleca of Disposition (Name of cemetary, crematory or other plece) 20c. Location - City or Town, State 1 Burlal 2 □ Cremetion 3 □ Removel from Stete LOUDON PARK CEMETERY 10/11/00 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funaral Service Licensee 22. Name end Address of Fecility LOUDON PARK FUNERAL HOME 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one causa on aach line. MD 21229 Approximete Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Final diseesa or condition resulting in deeth) MIN Examiner Due to (or, as a consequence of): Physician/Medical Examiner EUKEMIA LOGENOUS ettending physician and for use as the burial-tranait deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Lest Dua to (or as a consequence of): Box 68760, Due to (or es e consequence of): detached f Pert II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part f. 23b. Did tobacco use contributs to the cause of death? The law requires that the signed by t 1 Yss 2 7 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy been s after deeth.

I Director: After this certificate hes ad in by the funeral director, page 2 1 Yas 2 | No 1 ☐ Yes 2 No Physician: Be 25. Was case referred to medical 26. Piece of Daeth (Check only ona) Hospital: 1 ☐ Inpatient Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 20 ER/Outpatient 3 DOA 2 1 Yas 2 No 27. Mannar of Deeth 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: Injury at Work? or Attending 5 Panding invastigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledga, daeth occurred at the tima, data and place, and due to tha cause(s) and mannar as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et tha time, data end place, and due to the cause(s) end mannar stated. 29a. Certifier edicai one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier KUKO MI 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

State

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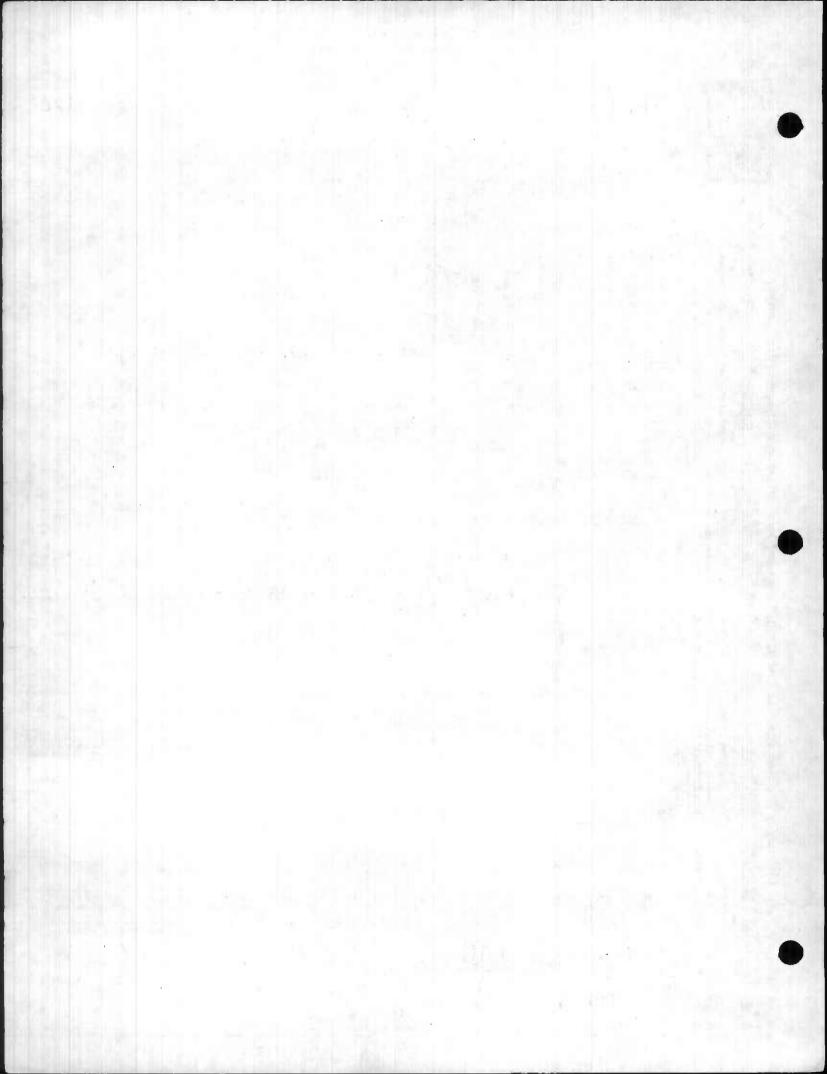
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32. Registrar's Signature

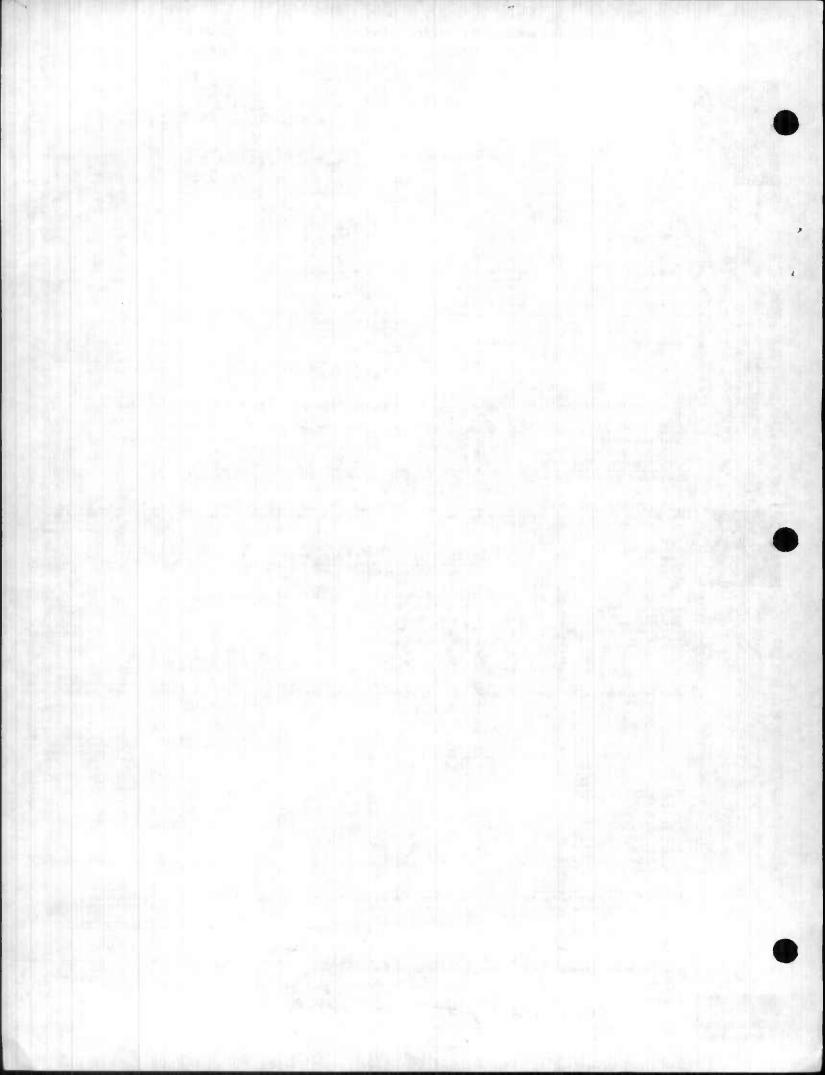
MD

CANCER CHR. 22 S. GREENE ST



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🗋 🗋 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Vaar **Physician** THEM PSON RICHARD MELVIN 823 2000 Oct /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c/County of Death Examiner Som pri TAN Hospital NID BOIHMORE 6000 If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number If Undar 1 Yaar 6. Sex 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** M 20 F Months Days 212 28 0471 Yrs. Director Hor. 22, 1931 Usual Rasidance of Decedent 10a Stata 10b County 10c. City. Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hydiene.
Important: if item 27 is marked other than "natural", or hems 23s or 28s-f show any Injury or other traumatic event, its Predict Examinal must be noticed.
DOGS. 1 Yes 2 No Director BALHAUR Marylons 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21218 HOMESTERD STYEET USB 706 Funeral 12. Was Decedent Evar in U.S. Armed Forcas? 1974as 2 1 No Korbins If Yas, Gha Year or Datas: Corffict 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian. Black, Whita, atc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: 18 /ac/c þ 3 Nidowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) BINDERY Buok Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST 8 4 grade 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) WILLIAMS THampson -1040 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) ABINGDON, Marylow 21009 Ruskin Gort Karen BELARUIS Doughke 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 10/16 20c. Location - City or Town, Stata Owings Mills, Marylons Burial 2 Cramation 3 Ramoval from Stata Tovest Veterns when Owings Mills, Marylor 22. Nama and Address of Facility CANTON - Homes Funeral Home 5240 REISTERETORN ROAD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensee 52.40 23a. Part I. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batw Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Diseane (aronan Examiner Dua to (or as a consequence of) Examiner Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated evants rasulting in daath) Last and Box 68760 Physician/Medical Dua to (or as a consequence of): manne Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, py 24b. Ware autopsy findings availabla prior to complation of cause of death? 24a. Was an autopsy Completed 1 Yas 2 No 1 Yas 2 No Hospital or Attanding Physician: 25. Was case rafarred to medicat axaminar? Be 26. Placa of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 1 Yas 2 No Certification: To 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No To the Hospital or Attandir within 24 hours after death, To the Funeral Director: Af invastigation 2 Accidant 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 6 Could not be datermined 3 Suicide 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 2 4 Homlcida 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. edical 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. Licansa number 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of certifiar D 316464 10/12/00 30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print) Rall mo Eutam St Font 30 P A. Hastomi 821 N. 2000 32. Registrary Signature OCT 13 31. Data filed (Month, Day, Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32407 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Year **Physician** Mary C. Tasker 2000 9 4:25 P.M. October /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Multi-Medical Center Towson Baltimore If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) # Under 1 Year Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days 1 M 20 F Hours 215 01 2981 Director March 21,1913 Maryland Usual Rasidance of Decedant the Maryland worle 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hams 23s or 28s-f show the Magical Examiner must be notified at 1⊠ Yes 2 No Director Maryland Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 S. Poppleton Street 21201 U.S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, etc. 72 hours efter 1 Yas 22 No If Yas, Giva Year or Datas: 1 Navar Marriad 2 Married 3altimore, Maryland 21215-0020 1 Yes 2K No Specify: Specify: à White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Cafeteria worker Maryland Drydock 12th 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) . Peges 1 end 2 should be filment of Health end Mental Hant: if Nam 27 la marked offlury or other traumatic aven Be Josephine Klisczwska Julian Stelmach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Leo Holden Nephew 102 S. Poppleton Street Baltimore, Maryland 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Mathod of Disposition 20c. Location - City or Town, State Data 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Department 10/12/00 Baltimore, Maryland New Cathedral Cemetery 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 one 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final weghi disaasa or condition rasulting in death) Examiner Physician/Medical Examiner sician and bunal-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiated evants rasulting in death) Last physician s the bunal P.O. Box 68760. Dua to (or as a consequence of) 88 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? April For lation 1 Yes 2 No 3 Probably 4 Unknown been signed t should be det Records, þ The lew requires Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital Attending Physician: Be 25. Was casa rafarred to madical examinar? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas 2D No 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 1 Natural 5 Pending invastigation 1 ☐ Yes 2 ☐ No death. 2 Accidant Hospital or Attandi 24 hours after death Funeral Director: A 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) in by 4 Homicida Pelli 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29a. Cartifian Medical completely 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. within 2 2

State

Registrar

31. Data filed (Month, Day, Year)

29b. Signature and title of certifier

MD 32. Flegistrar's Signatura Senew

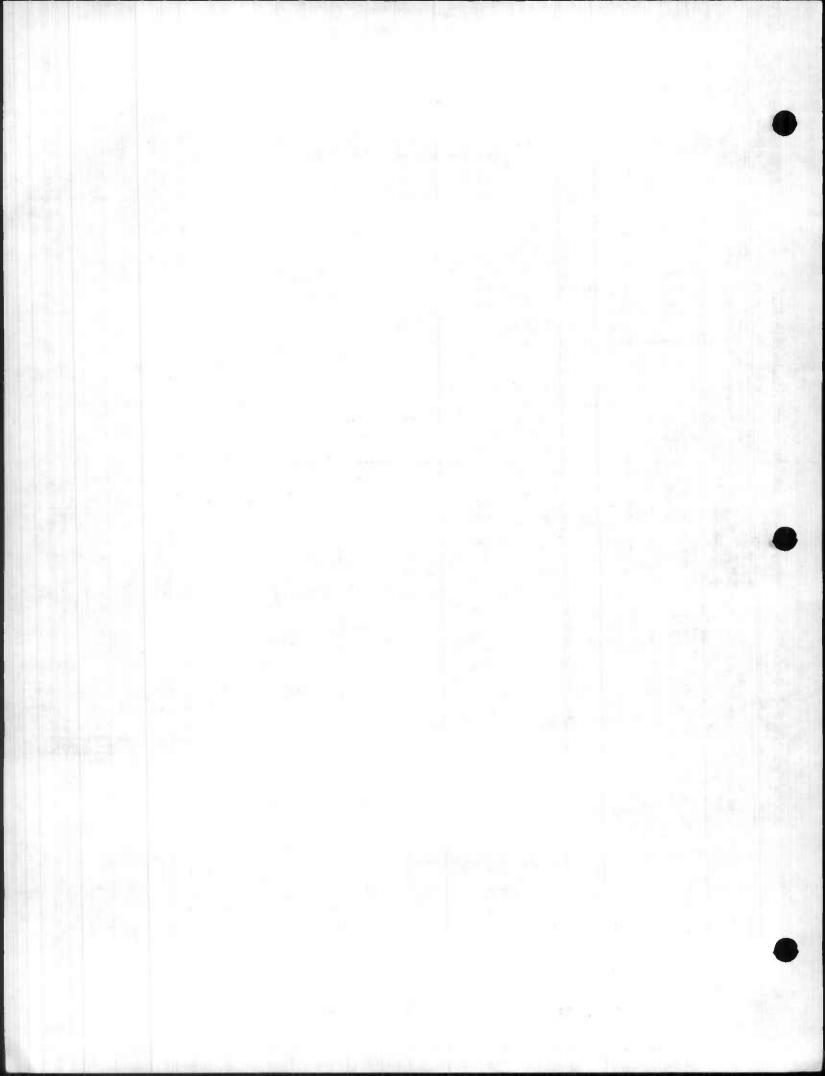
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 115E Melore AVE 21212

017118

29d. Data signed (Month, Day, Year)

Uct 10, 2000

29c. License number

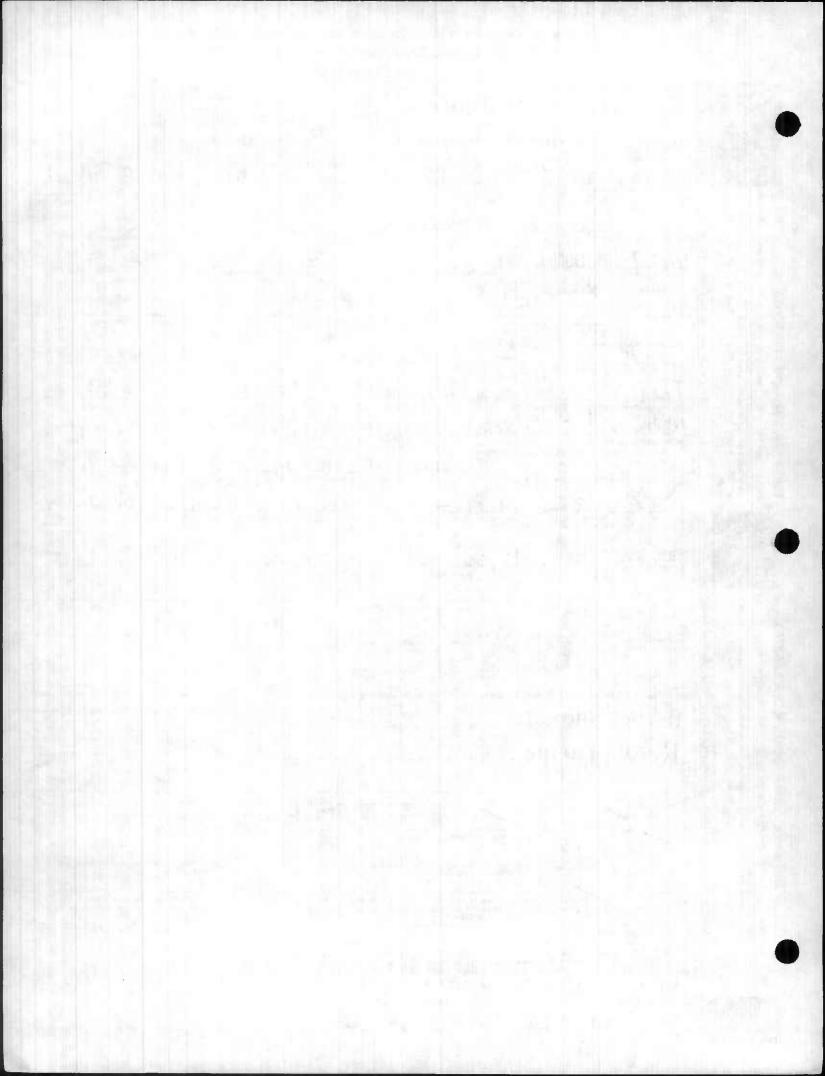


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October **Physician** swald Vonbehren 16:45 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Samaritan Hospital Baltimore 5000 If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F 213-05-2627 Usual Residence of Decedent Male Director 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 Funeral 000 filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 11. Merital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 💢 No Specify. by 3 ☐ Widowed 4 ☐ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill ment of Health and Mentel Health and Mentel Health are filled officers or other traumatic even 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numbe or Rural Route Number, City or Town, State, Zip Code) 21111 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State riment o moter 2000 4 ☐ Donation 5 ☐ Other (Specify) permit. F Departm Importar any Injur EVANS Funeral Chapel 22. Name end Address of Facility Rd Baltemore 8800 Hapford Rd. Baltum.

Baltum Baltum and the mode of dying such as cardiac or respiratory arrest, Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown Division of Vital Records. Be Completed by 24b. Were eutopsy findings evailable prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 The patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 Natural Injury after death. Director: Aft 2 No 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 112 certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier To the Vithin 2 To the Complet 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P12558 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) och Rowen Mara onabedian 560 31. Date filed (Month, Day, Year) 32. Registrat's Signature Registrar

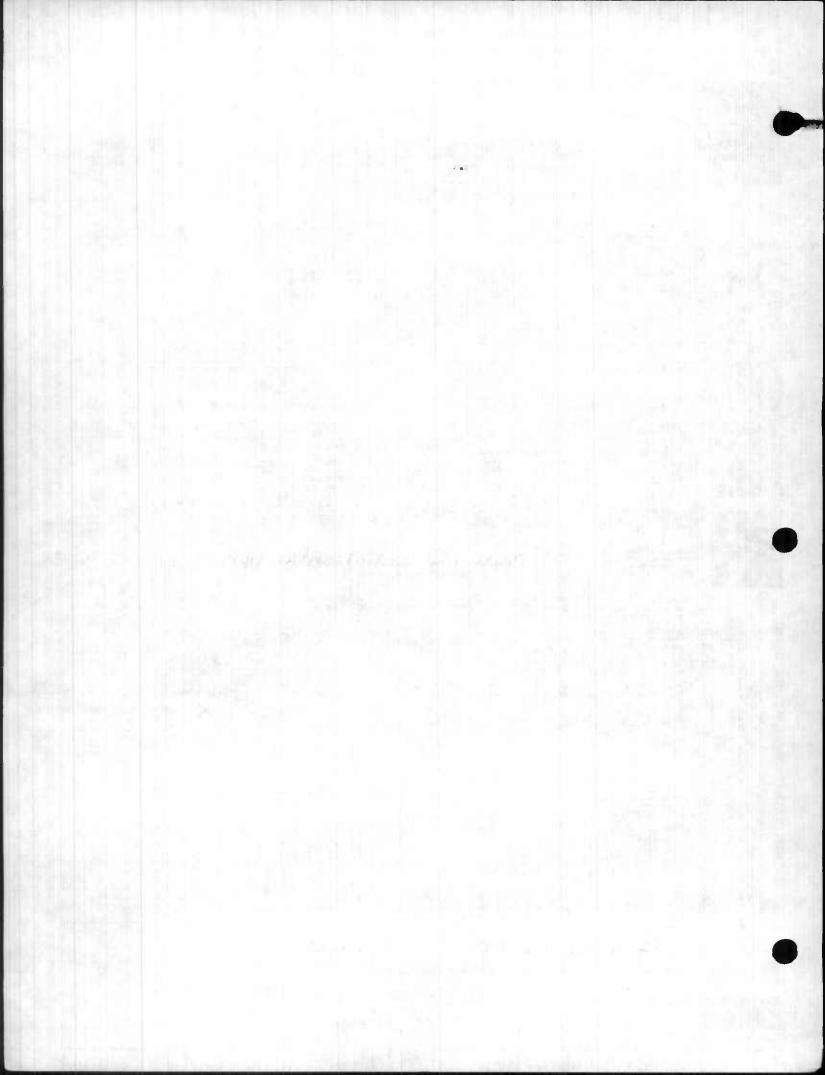
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State of Maryland / Department of Health and Mental Hygiene 0 3 2 4 0 9

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xaminer	4a Facility	Name (If not instituti	ion, give s	treet and number	or)				4b. City, To	wn, or Lo	cation of Death	4c. County	of Death		
		Joseph's	Medi	ical Cer	ter	-100			Tows			Balti			
neral	5. Social S	Security Number	6. Sax	M 2□ F		last birthday)	If Und	Days	If Under:	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State try)	or Foreig
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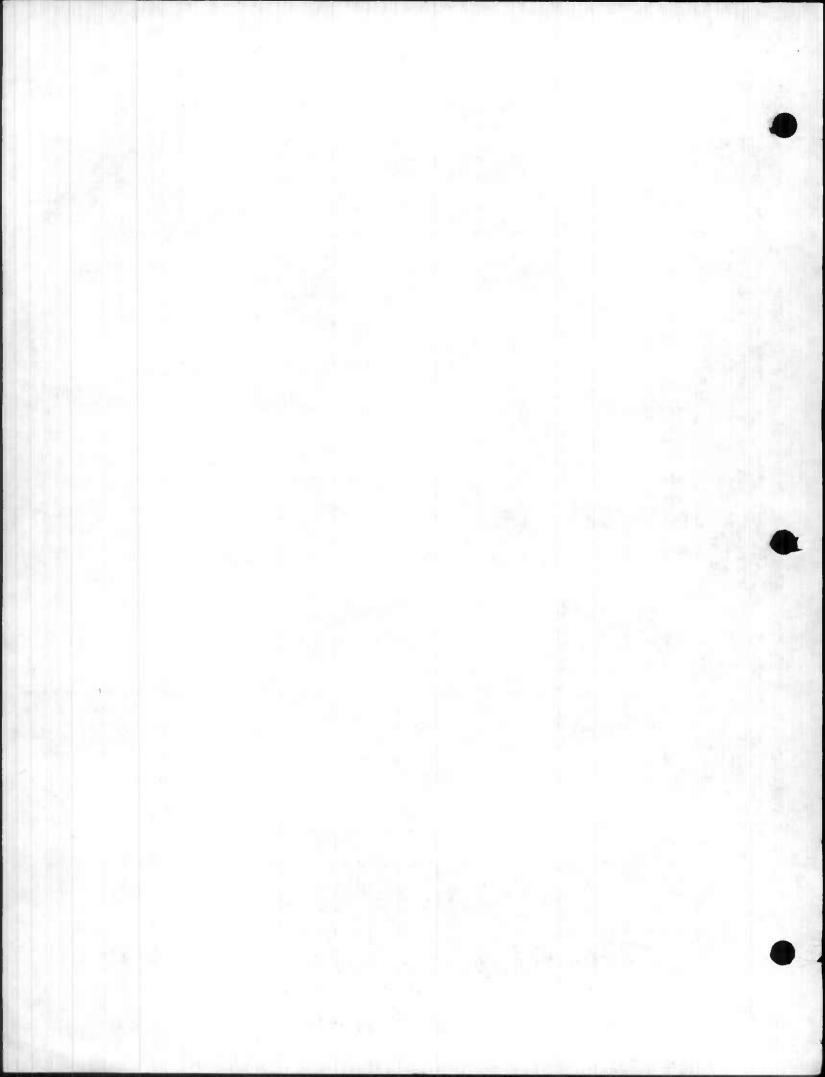


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State Registrar OCT 1 3 2000 Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Signature Apark,					-	r's Signature	32. Regi			State				

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** October 2000 Maud Н. Wadford 1:25 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1473 Gesna Drive Hanover Anne Arundel If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2□ F 220-70-0412 68 Director FEB. 23, 1932 British Honduras Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Howard Laurel 1 ☐ Yes 2 No Director 288-7 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ŏ 448 Old Line Ave. 20724 **IISA** 234 Funeral natural, or Itams 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, elc. 11 Marital Stalue 1 Yes 2 XNo
If Yes, Give
Year or Dates: filed within 72 hours after 1 Never Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Health Aid Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Surnama) Pages 1 and 2 should be fit ment of Health and Mental H ant: If Nem 27 is marked off Be Herbert Lind Maud Sebastian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) or other tra Kathy Chrystal - daughter 1473 Gesna Dr., Hanover, Md. 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dale 20c. Location - City or Town, State 10/17/00 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cem. 4 □ Donation 5 □ Other (Specify) Arlington, Va. Depart Import any in 22. Name and Address of Facility
Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 21. Signature of Funegal Service License 260 7250 Washington Blvd., Elkridge, MD 21075 23a. Part Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, nor heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical macen Examiner to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760, Physician/Medical Due to (or as a consequence of): for use r P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy 1 Yas 2 000 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, 25. Was case refarred to medical examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) Certification: To 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral completely f 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, data and place, and dua to the ceuse(s) and manner stated. edical 29a. Certifier 29b. Signature and liftle of certified 29c. License number 29d. Date signed (Month, Day, Year) 124356 900 Saton Aux ted ceuse of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

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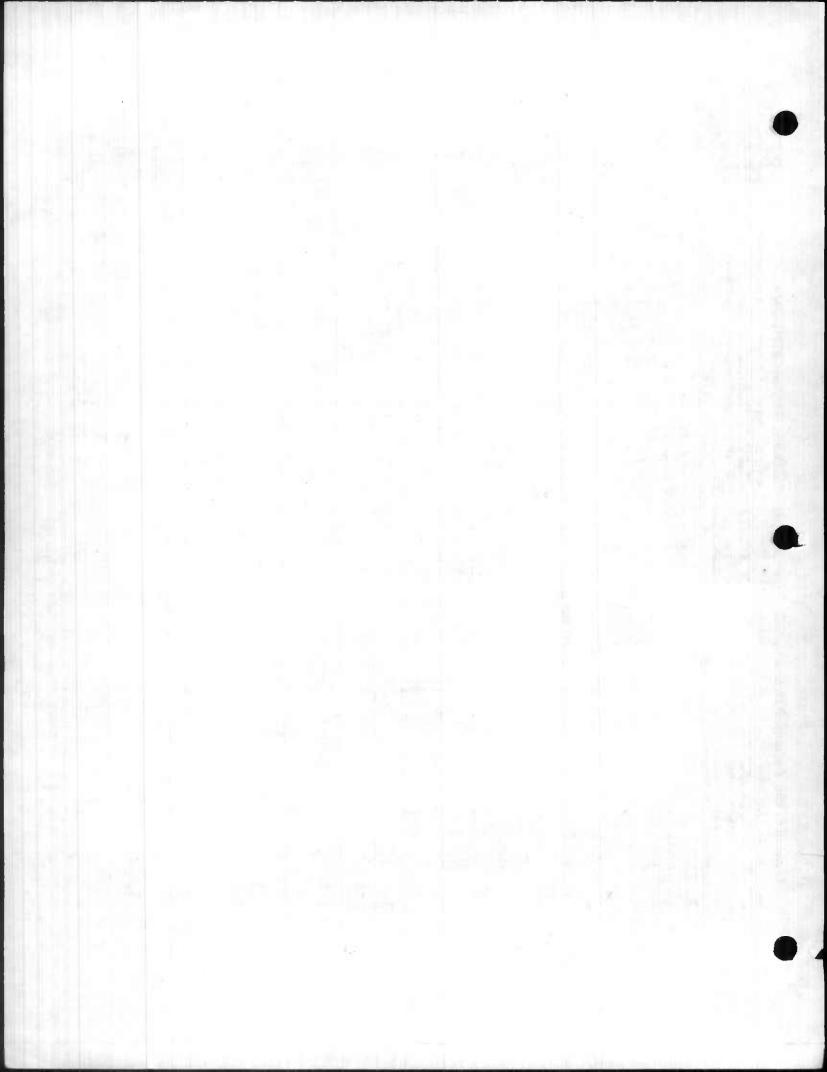
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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Death Month 3. Time of Death 10:35 PM John Earl Wallace 10, October 2000 4a Facility Neme (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Harbor Hospital Baltimore If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) 1 ☑ M 2 ☐ F 218-14-0900 Dec.23, 1924 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 604 Cleveland Road 21090 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1XXYes 2 □ No If Yes, Give Year or Dates: Army 1 ☐ Yes 2 ☑ No Specify. Specify white 3 Widowed 4 □ Divorced 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Stone Mason Self-employed 5 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Wallace Emma Griffin 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mary Wallace - daughter 604 Cleveland Rd., Linthicum, Md. 20c. Location - City or Town, Stete 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 1 XBuriel 2 Cremetion 3 Removal from State 10/13/00 Meadowridge Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fugerel Service Licenses 22. Name and Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 21075 Immediete Cause (Finel disease or condition resulting in death) rchythmin CardioViscolar Vigeose Sclerotii Due to (or es a consequença of) 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 → Onknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? 1 Yes 2 10 1 ☐ Yes 2 ☐ No 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

P.O. Box 68760.

Records,

Division of Vital

Physician

/Medical

Examiner

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Funeral

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items 23a

permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: if item 27 manked other than "natural", or items 23 any Injury or other traumatic avent, the Medica Estatus many Injury or other traumatic avent, the Medica Estatus man

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in death) Last þ Be Completed

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Wes case referred to medicel

1 Yes 2 No 27. Menner of Death 1 ☑ Natural 28a. Dete of Injury (Month, Dev Year) 28b. Time of 5 Pending investigation 2 Accident 6 Could not be determined

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, State)

1406BS. Crain Glen Burnie MD 21061

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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3 Suicide

29a. Certifier

4 ☐ Homicide

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29c. License number 29d. Date signed (Month, Day, Year) 00

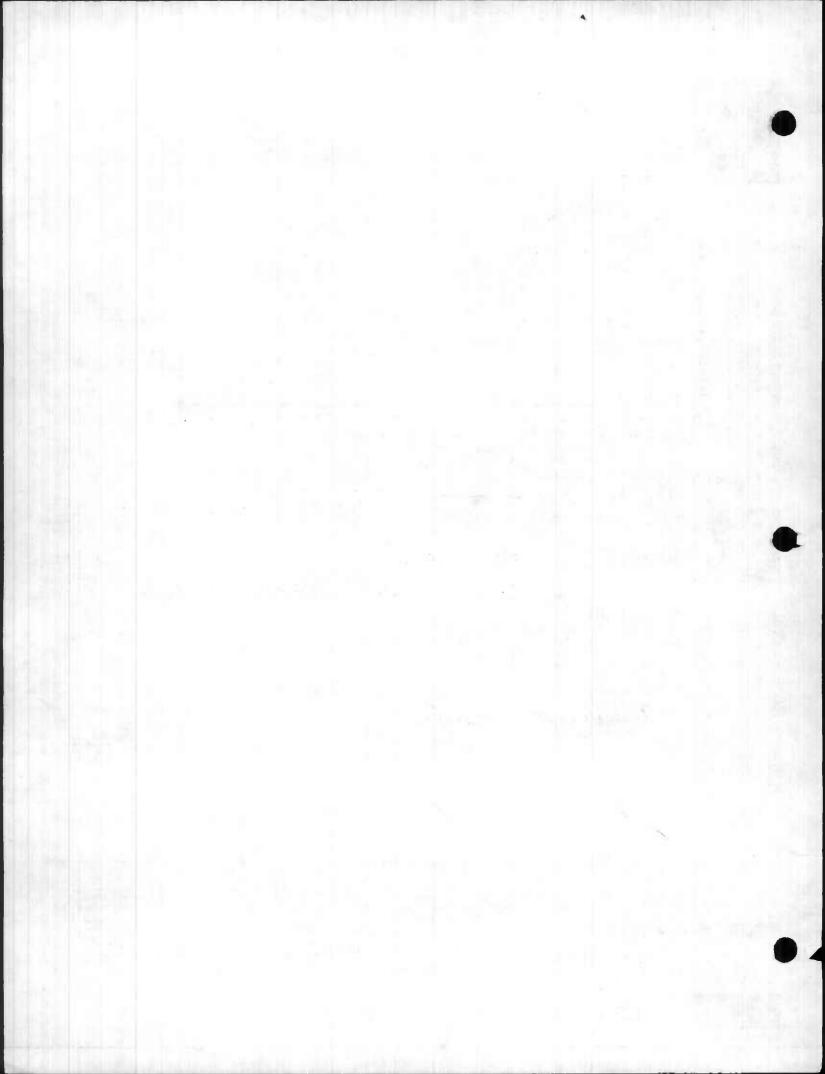
State Registrar

Medical Certification: To

31. Date filed (Month, Dey, Year)
OCT 1 3 2000

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Funeral Director

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State of Maryland / Department of Health and Mental Hygiene David Alan Weidner State of Waryland, David Alan Weidner # 23a,27,28a,b,c,d,e,d,f 11-13-00 G-789d Certificate of Death

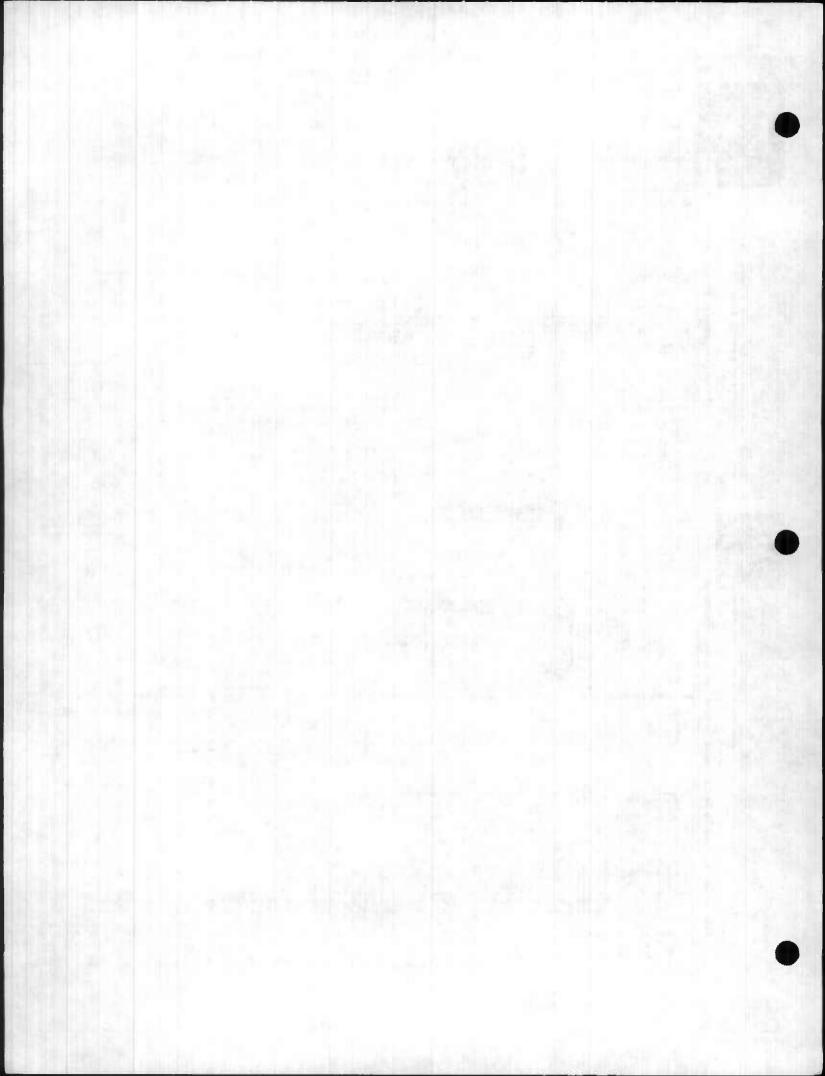
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Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marrial Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumetic event, the Madical Examiner mast be notified at more
	Physiciar /Medica
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be datached for use as the bunial-trensit and property.

1. Doublett S Name (First, Micure, La	David Al	lan Wei	dner				Month	Day	Year 000	2:30 P.M
4a Facility Name (If not institution, give					4b. City, To	wn, or Lo	cation of Death	4c. County	of Deeth	
Northwest Hospit	tal Center						town	Bal	timor	
5. Social Security Number 6. S 214 54 9130	M ALLE	In yrs. last birtl	rs. If Unc	der 1 Year is Deys	If Undar Hours	Min.	8. Date of Birtl (Month, De) Dec • 16	r, Year)		aca (Stete or Foraign try) yland
Usual Residence of Decedant 10e. State 10b. County	1	Oc. City, Town	or Logation						14	Od. Inside City Limits
Maryland Carrol		Elders								1 Yes 24 No
10e. Street and Number			10f. 2	Zip Code		5214		10g. Citizen of V	Vhet Coun	try?
2310 Todd Lane				217	84			U.S		
11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 20 Divorced	12. Was Decedent Even Armed Forcas? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	er in U,S.	If Yes, sp	pecify Cuba	lispenic Ori an, Mexicar Specify:	n, Puerto	ecify Yes or No- Rican, etc.)	14. Rac Blac Specify	e - Americ k, White, d Wh	
15. Decedent's E (Specify only highest green Elementary/Secondary (0-12)			Decedent's Us (Give kind of the life. DO NOT	work done use retired	during mos d)			16b. Kind of Bu		lustry
12	1 year	E	lectro	nic T	echni	cian		S.A.	F.T.	
17. Father's Neme (First, Middle, Last)				18. Mothe			Maiden Sumerr		9.45-107
J	oseph A. We	idner				Do	rothy Pl	hyliss 1	Lackw	itz
19a. Informent's Name/Relationship (r, City or Town,		
Joseph Weidner	/ Father		10 Tode		e	E1de	rsburg,	Maryla	nd 21	784
20a. Method of Disposition 1 Burlal 2 Cremation 3	Communitary State	20b. Pleca of cematary	Disposition (A	verne of or other plea	ce)		Dete	20c. Location -	City or To	wn, State
4 Donation 5 Other (Special		Bayvie	w Crema	atory	, Inc	. 10	0/5/00	Baltimo	ore,	Maryland
21. Signature of Funeral Service Lice	nsee	. 6			ss of Fecili	. (uneral limore, l		
23a. Part1. Enter the disease, or part shock, or heart failure.	lications that caused th	e death Do n	1						11.10 2	Approximata Interval Between
Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	ua to (or as a co								
that infilled events resulting In death) Last	d.	a to (or as a co	onsequan <i>ce</i> o	f):						
Part II. Other significant conditions of	contributing to death but r	not resulting In	tha underlying	g cause giv	ren in Part	1.	23b. Dld t	obacco uas co	ntributs to	the cause of death?
										bably & Unknow
							24a. Was perfo	an eutopsy rmed?	avi	ere autopsy findings allable prior to appletion of cause death?
Charles The Park							185	es 2□No	15	Yes 2□ No
25. Was case referred to medical examiner?					26. Place	e ol Deetl	h (Check only o	ne)	-	
1 Ves 2 No	Hospitel: 152 Inpatient	2□ ER/Out	patient 3	DOA Oth	ner: 4 No	ursing Ho	me 5 Resid	lence 8 Oth	er (Specif	1)
27. Manner of Deeth 1 Naturel 5 Pending 2 Accident invastigatio	28a. Date of Injury (Month, Dey Y 9-26-00	(ear) 28b. Ti	ime ol ijury 5:00р м	28c. Injui Wor	yet rk? Yes 2 🔀		28d. Describe h unknown	now injury occur	red	
3 ☐ Suicide 6 ☐ Could not be determined		- At home far (Specify) FO	m street fect	ory offica			281. Location (5 City or Tow REISTERS	Street and Number, State) 32 TOWN, MD	Brook Apt	ebury Dr., D1
29e. Cartifier (Check only one) 1 Certifying Ph	nysician: To the best of r niner: On the basis of ex and manner state	camination and	death occurre Vor investigati	ed at the tir on, in my o	me, date ar opinion, dea	nd placa, ith occurr	end due to the ded at the time,	ceuse(s) and me date and place,	end due to	ated. the cause(s)
29b. Signature and title of certifier	0.0			29c. Licens	e number			29d. Date signe	d (Month,	Day, Year)
Dennis 20	luten			0.	C.M.E	•		October	04,	2000
30. Neme and address of person who	completed cause of deal		**	n Str	eet.	Balt	imore.	Marylan	1 212	01
31. Date filed (Month Day Year) 3	2000 32. Registrar's		4	1				7		

DHMH 16 Rev 6/95

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Month Yee **Physician** EMM DEPTEMBER16,2000 /Medical 4e Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Hopkins 6. Sex Hospital A TIMO V C. If Under 24 Hrs. 8. Dete Johns If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Deys Months 1□M 20 F Hours Director 220-34-1571 02-Apr-36 Maryland Usuel Residence of Decedent the Maryland 10e. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f ahow treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director Garrett Maryland Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Wilhelm Lane or Nema 23a 2 should be filed within 72 hours after death n end Mental Hygiene. Is marked other than "natural", or itema 23. 14. Raca - American Indian, 21532-13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 Yes 2 No 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2 PNo Specify: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 homemaker homemaker Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Lawrence L. Layton Clara E. McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Stephen C. Albright 9 Wilhelm Lane Maryland husband Frostburg 21532-20a. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 19-Sep-00 Finzel, Maryland **Layton Cemetery** 21. Signature of Funeral Service Licensi 22. Name end Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 one 23a. Pent Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Finel diseese or condition resulting In death) /Medical CARDIOPULMONARY ARRE Examiner Physician/Medical Examiner been signed by the attending physician end should be detached for use as the bunal-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events Box 68760. thet Initieted events resulting in death) Last Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? After this certificate has VEUTROPENIA 1 Yes 1 Yes 2 No sapitat or Attending Physician: Thours after death. Inerel Director: After this certificate filled in by the funeral director, px Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28b. Time of Injury 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

To the Hospital within 24 hours a To the Funeral C completaly filled

ms

Registrar

ROGENE 31. Dete filed (Month, Dey, Year) State SEP 1 8 2000

29b. Signature and title of cartifier

29a. Certifier

DRIVE 32. Registrer's Signeture

exand

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Apartment T3

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated.

29c. License number

RES-000

BALTIMORE, MD

29d. Date signed (Month, Dey, Year)

17,2000

10.1-6-15

Maryland Carlett Fostbring

Wilhelm me.

L_1 -9558

ALC: NO

P2-Api Ga Morriflond

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Lawrence Lilavian Clara E. McKenzie

Stephen C. Albright 1978-947 Switzelm size Figithurg Minylot 21-312-

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene 3 2 5

			State of Marylan		ficate of			Reg. No.	02910	20
	Diameteries.	1. Decedent's Nama (First, Middla, Last)					2. Date of De Month		3. Tima of I	Death
	Physician /Medical	PREJEKTIK PROPINE ATRESMAN					OCTOBE			
	Examiner	4a Facility Nama (If not institution, give s	street and number)			4b. City, Town, or L	ocation of Deat	4c. County o	of Death	
Ĭ		1307 KENTUCKY AVE			f Hadas & Vans	CUMBERLA			EGANY	
	Funeral Director	5. Social Security Number 6. Sax 172 172 172 172 172 172 172 172 172 172	7. Aga (In yrs. 60		f Under 1 Yaar flonths Days	Hours Min.	8. Date of Bir (Month, Da AUGUST		Birthplace (Steta or Country) MARYI.ANI)	Foreign
2	,	Usual Rasidance of Decedent								1.15-21
aryle	ahow at the								10d. Inside Cit	,
P M	or 28a-f a	MARYLAND ALLEGAN 10e. Street and Number	Y	CUMBERLA				40-02		20100
with	Dir	1307 KENTUCKY AVE	MHE		10f. Zip Code	1502		10g. Citizen of What Country? U.S.A.		
Seath	r items 23. niner must Funeral		12. Was Dacedant Evar in U	Was Dacedant Evar in U,S. Armed Forcas? 1 □ Yas 2 □ No If Yas, specify Cuban, Mexican, Puarto Ricar If Yas, Sye Yaer or Datas: 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. Do NOT use retired)			pecify Yas or No		- American Indian,	
5-0020 72 hours after death with the Maryland	al, or items 23a or 28e-f above Examinar must be notified at by Funeral Director	1 Navar Married 2 Married 3 Widowed 4 Divorced	Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaer or Datas:						, Whita, atc. WHITE	
Maryland 21215-0020	ygiene. Net then "neturel", It, the Medical Earl Completed by	15. Decedent's Educ (Specify only highest grade Elamentary/Secondary (0-12)	cation a <i>complated)</i> Collega (1-4or 5+)				king	16b. Kind of Bus	iness/Industry	
d 2	Hygie ther the true of Co	12+ 2 17. Fathar's Nama (First, Middle, Last)		CITY O	F CUMBE		a (First Middle	ENGINEE Maiden Sumama	RING DEPT.	
and	Mental Hy arked other artic avam, To Be C	HARRY AIRESMAN							,	
aryla	a mark	19e. Informent's Name/Ralationship (Type	ne. Print)	19b. Mailing A	Addrass (Street	and Number or Rui	S McDON		Stata: Zin Code)	
, Ma	575	BONNIE AIRESMAN	WIFE			AVENUE C				2
s i a	9 5 5	20a. Mathod of Disposition	20b. P	Place of Disposition	on (Name of		Data		City or Town, Steta	
mor Peges	mt: #	1 Burial 2 Cramation 3 R. 4 Donation 5 Other (Specify)	amoval from Stelle	BERLAND			2000	CUMBERLA	ND MARYLAN	D
Baltimore,	Departmen Important: any injury phes.	21. Signature of Funaral Sarvice License	LL	MEL	ama and Addre	AMC FINE	RAL HOM	E P.A.		
		23a. Part1. Entar tha disease, or complice shock, or heert failura. List only on	cations that caused the deat	h Do not anter t	DECATI	JR STREET	CUMBER:	LAND MAR	YLAND Approximete	
* I	ysician Medical caminer	shock, or heert failura. List only on immediate Cause (Final disaasa or condition rasulting in death) a	9 nosta	ge L	bress	to			Interval Betwonset and D	veen
De la companya de la	nsit	Due to for as a consequence of): Due to for as a consequence of):								
58760, icete be execut	o physicien and as the burial-transit									
	0 8 -	rasulting in death) Last	Dua to (o	r es a consequen	ice or):					1
. 5	d for	Part II. Other significant conditions con	tributing to death but not res	ulting in the unde	riving course giv	ren in Part I	23h Did	tohacco use con:	tribute to the cause o	f death?
P.O.	ed by the ettending detached for use a Physician/M	Respirato	4 failure						3 Probably 4 t	
Records,	page 2 should be del	- 0	0				24a. Was perfo	an autopsy ormed?	24b. Wara autopsy fi eveilable prior to completion of ca of death?)
	page Com						10	Yes 2 No	1 □ Yas 2 □	No
Vital	s certificate director, pay To Be Co	25. Was casa rafarred to medical axeminar?				26. Place of Deel	th (Check only	one)		
O A	T SE	1 ☐ Yas ②CXNo 27. Mannar of Death 1XCNatural 5 ☐ Pending	ospital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Input (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA Oth	y at k?		dence 6 Othe		
> 5	Sire by	2 Accidant invastigation 3 Suicide 6 Could not be 4 Homicida determined	28a. Place of Injury - At he building, atc. (Specification)	ome, farm, street,		Yes 2 □ No	No 28f. Location (Street and Number or Rural Routa Number City or Town, Stata)			ber,
- Hospital	within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Cartifier (Check only one) 29a. Cartifier (Check only one)	Ician: To the best of my knower: On the basis of axamine and mannar stated.	wledge, daath oc tion end/or invest	curred at tha tir tigation, in my o	ne, date end place, pinion, daath occur	end due to the red at the time,	cause(s) end mer date and plece, e	ner as stated. nd due to the cause(s)	
To the	ompl	29b. Signatura and titla of certifiar	1.	do	29c. Licens	e number		29d. Data signed	(Month, Day, Year)	
	1	1/10	COSONOVI	30	D 2218	31		OCTOBER :	3, 2000	
	10	30. Nama and address of person who co			nt)				F111E	
	MAS	DR GARY L. WAGONE			KIVE CL	MBERLAND	MAKYLA	ND 21502	4	
	State Registrar	OCI 04 2000	32. Registrar's Signa	ture de	souls					

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Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey Year **Physician** 4b. City, Town, or Location of Death
Haccord RUSSELL NMN BRECHBILL /Medical 4a Facility Name (If not institution, give street and number) Examiner Washington County Hospital Hagerstown Washington County 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number Months Days **Funeral** 204-03-5086 10XM 2□ F 91 Yrs. Aug. 14, 1909 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Washington County Smithsburg Director Hydenta. other than "natural", or flams 23s or 28ser rent, the Medical Examiner must be notifis 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20837 Jefferson Boulevard 21783 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Merried 2 ☑ Married Specify: White 1 Tyes 2 No Specify: PV 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Elementery/Secondery (0-12) College (1-4or 5+) Aircraft Manufacturing Machinist 0 8 Maryland 18 Mother's Name (First Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) ed bluode marked Ida Elizabeth Cramer Harvey Brechbill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Pages 1 and 2 Glenna E. Brechbill/Wife 20837 Jefferson Boulevard, Smithsburg, Maryland Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State ò Department of important: If sary Injury or affice. Sept.30 Air Hill, Pennsylvania Air Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
Douglas A. Fiery Funeral Home 21. Signature of Funeral Service License 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 Part 1. The the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Conditionaralla aher Arterio relendire **Examiner** Due to (or es a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or Injury that initiated events Due to (or as a consequence of): Due to (or es a consequence of) resulting in death) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Mallitas chonic þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? Probable After this certificate has Protecti 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Dey Year)

Attending 6 To the Hospital within 24 hours a To the Funerel E

> State Registrar

Director:

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) DA. Datta 334 m: 11

- CANTE MO

31. Date filed (Month, Dey, Year) OCT 0 2 2000

5 Pending investigation

6 Could not be determined

27. Menner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 \ Homicide

29b. Signature end title of certifier

32 Flegistrar's Signature Deperre

28c. tnjury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

P18019

1 Yes 2 No

28d. Describe how injury occurred

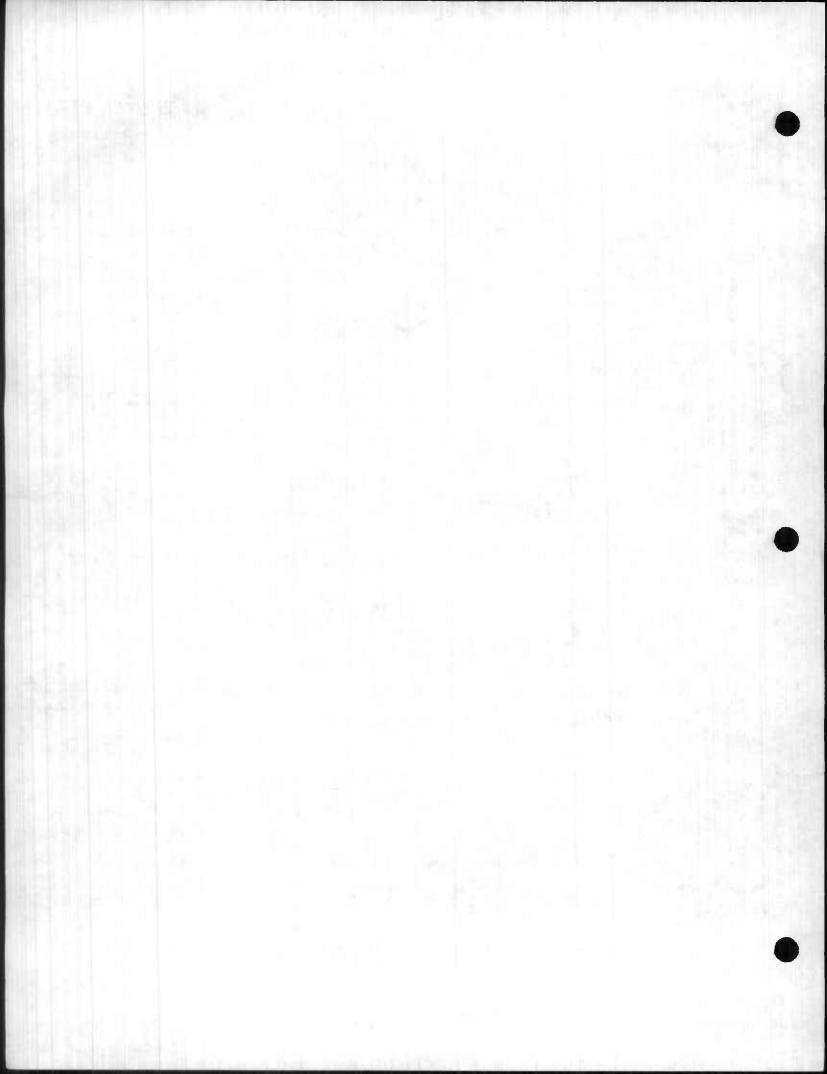
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

Sept 28, 2000

28b. Time of Injury

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

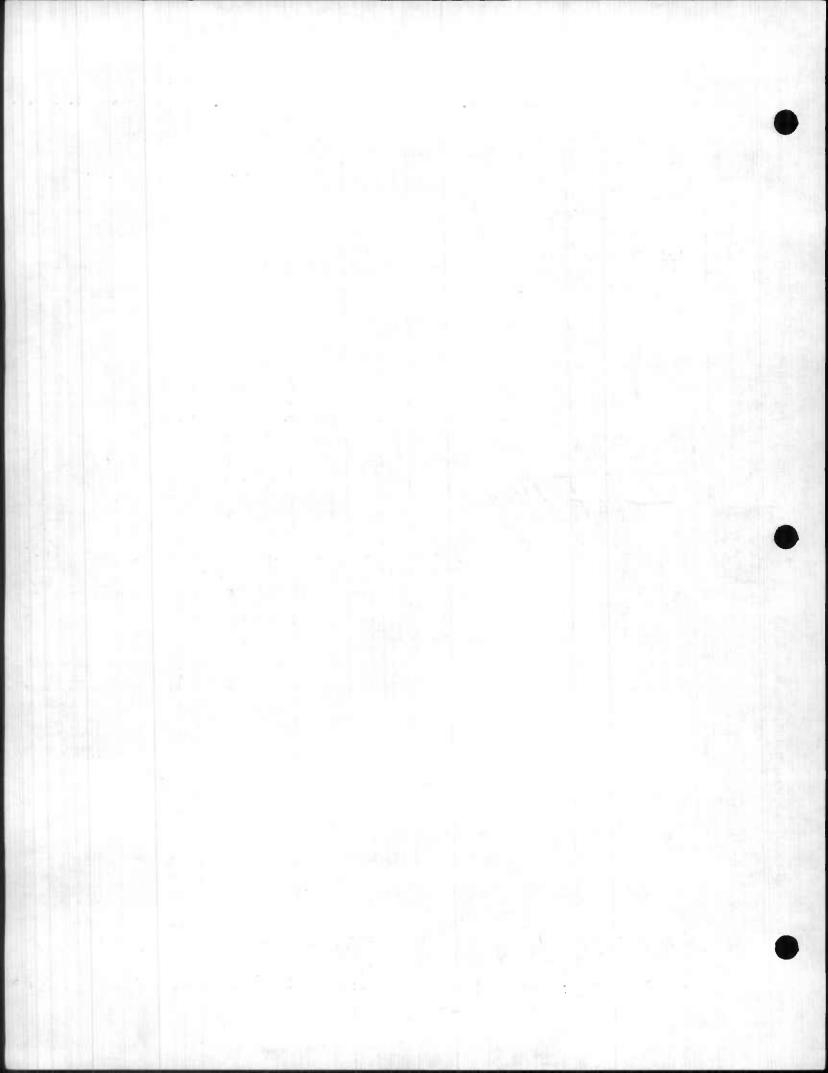


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death Day 28 Physician 2000 11:03 p.m Sept. Richard Lee Barnes, Sr. /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 135 Plantation Drive Hagerstown Washington If Under 1 Year | If Undar 24 Hrs. 7. Age (In yrs. last birthday) 71 Yrs. Birthplaca (Stata or Foraign Country) 5. Social Security Number 8. Data of Birth (Month, Day, Year) **Funeral** Hours X□M 2□F Months 578-36-4765 Director 10/13/1928 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at 1 Yas 2 No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21740 U. S. A. 135 Plantation Drive death Funeral Reme Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, Black, Whita, atc. filed within 72 hours after 1 TYes 2 No 1947 If Yes, Give Year or Dates: 1948 1 Never Married Married altimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 1948 Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government Painter 10 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) permit. Pages 1 and 2 should be fill.
Department of Health and Mental Hy
Important: If Item 27 is marked oth
any injury or other traumatic even 8 Ada Burgess Alva E. Barnes 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Hagerstown, MD 21740 135 Plantation Dr. Lois Ann Barnes / spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 10/2/00 Hagerstown, MD 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rest Haven Funeral Chapel Hagerstown, MD 21742 1601 Pennsylvania Ave. Approximate Interval Between Onset and Deat Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner leading to immedi Enter Underlying (Disease or injury Box 68760 Physician/Medical Due to (or as a consequence of): P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of degth? Unknown 1 Yes 2 No 3 Probably Records, à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 TYes 28b. Time of 27. Manner of Dec scribe how injury occurred 28c. Injury at Work? 5 ☐ Pending investige Natural 1 Yes 2 No Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after de Directe ò e Funeral D Certifying Physician: 70 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 7 29c. License number 29d. Date signed (Month, Day, Year) th (Item 23a) (Type, Print)/ DINWOOD

State Registrar

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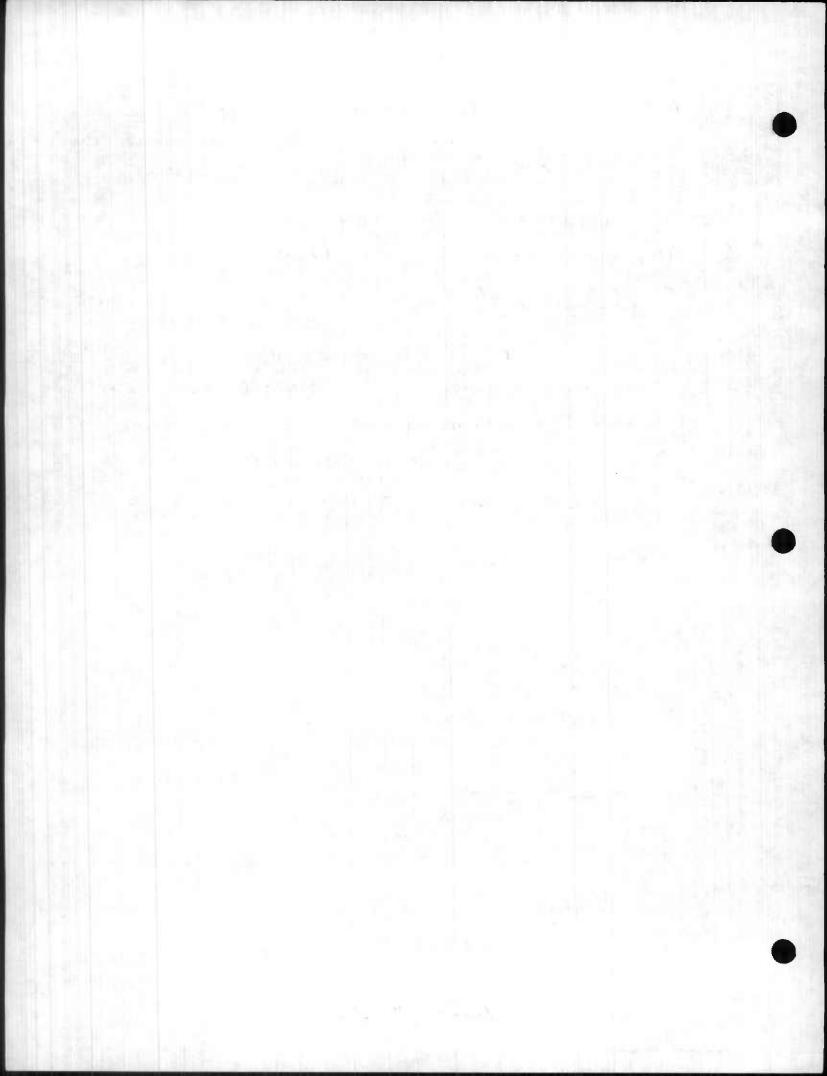
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Aldus Sharon BoneBrake

		State of Maryland / Department of Health and Certificate of Death		giene	32418	
		Decedent's Neme (First, Middle, Last)	2. Dete of Dee	eth	3. Time of Death	
	Physiciar /Medica	ALDUS SHARON BONEBRAKE	Sen Par	or 28 2	000 23:10	
	Examine		r Location of Death		Death	
_		TOTAL TOTAL CONTRACT THE SPIRIT	STOWN		INGTON.	
п	Funeral Director	5. Sociel Security Number 6. Sex 12M 2D F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 83 Yrs. 83 Yrs. 83 Yrs.	n. (Month, De)	Y, Year) 4, 1916 F	Birthplece (State or Foreign Country)	
Ь		Usual Residence of Decedeni	OCT	41191017	ALDEDICO, FIL	
	how	10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits	
	vith the Me or 28a-f	PA FRANKLIN WAYNESBORO			1 2 Yes 2 No	
	eth with the Meryland 23a or 28a-f ehow		100	10g. Citizen of Wha		
	fler deeth v	11. Maritel Status 12. Was Decedent Ever in U.S. 13. Wes Decedent of Hispenic Origin?	(Specify Yes or No-		American Indien,	
20		If Yes, Give 1 □ Yes 2 KNo Specify:	erto Rican, etc.)	Rican, etc.) Bleck, White, etc. Specify: WHITE		
5-0020	hour			16b. Kind of Busin		
215	ed within 72 ho ygiene. er than "netur it, tre Wide	15. Decedent's Subel Occupation (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Elementary/Secondary (0-12)	rorking			
2	filed wit Hygiene ther the	I COST ACCOUNTAN			G TOOL MFG.	
and	E HON	17. Fether's Neme (First, Middle, Last) 18. Mother's N	eme (First, Middle,		2001/	
7	d Men marker marker	19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Information of the Information of	REBE		ODY.	
Ma	od 2 should the end 27 le ma	LINDA M THORNTON/PAUG 501 CLAYTON AVE			PA 17268	
ore,	of Heer	20e. Method of Disposition 20b. Place of Disposition (Name of complexy complexy or other place)	Dete	20c. Location - Cit		
E	O == 0	4 Donetion 5 Other (Specify) GREN HILL CEMETERY	OCT 2	WAYNES	BORD, PA	
Balti	Departmentimportant: Pa	21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility	rove-Ba	USPSOX +	ZINEBAL HOME	
ш	80559				PA 17268	
N.		23e. Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart feiture. List only one cause on each line.	iac or respiretory er	rest,	Approximete Intervel Between Onset end Death	
	Physician /Medical Examiner	immediate Ceuse (Final disease or condition resulting in deeth) a. PNEUMOWIA				
		Due to (or as a consequence of): CONGESTIVE HEART FA	AICURE			
	executed n end ial-transit	Sequentially list conditions, if any, leading to immediate	HOULE			
,092	ite be execut ysician end he bunal-tran					
687	5 6 7	that initiated evenls Due to (or es e consequence of):				
Box (eath certifical attending phy for usa as th	a CRREBROVASCULAL ACCID	ENT			
B	death d for	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did 1	tobacco use contri	bute to the cause of death?	
P.0	ulras that the death certifical signed by the attending phid be detached for use as it is by Dhytellian as the bound of th	n reration	10	Yes 2□No 3	☐ Probably 4 Unknown	
ŝ	the de de de de de de de de de de de de de	VINSELES MELLIIS			/	
of Vital Record	The law requires that the death certifical tale has been signed by the attending phage 2 should be detached for usa as it is a substantiated by Dhysteles and the contributed by Dhysteles and the contributed by Dhysteles and the contributed by the state of the contributed by	DEKUBITIS DILCERS		en autopsy med?	24b. Were eutopsy findings eveilable prior to completion of ceuse	
Rec	0 - 5 -		10	res 2000	of deeth? 1 ☐ Yes 2 ☐ No	
ta	certificate rector, pag	25. Wes case referred to medical 26 Place of D	Peath (Check only o		1 ☐ Yes 2 ☐ No	
<u> </u>		examiner?	_	dence 6 Other	(Specify)	
	After this funeral d		28d. Describe	now injury occurred		
Sio	Attending ar deeth. ector: After by the fune	2 Accident Investigation 3 Suicide 6 Could not be				
Division	tal or Attending P rs after deeth. al Director: After t ed in by the funera	determined determined determined determined determined determined determined determined determined determined determined	City or Tov		or Rurel Route Number,	
			ce, end due to the	ceuse(s) and menn	er es stated.	
	in 24 hour in 24 hour he Funer plately fill	(Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death or end menner stated.	curred et the time,	date end piece, end	due to the ceuse(s)	
	To the con	29b. Signeture end tittle of certifier 29c. License number		29d. Date signed (i		
		DS2323	3	09/2	7/00	
		30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) HALID WASEEM 19414 C CIRTERSBUR	(Pir 2	HACE	CL MUSCOUS	
	State	31. Dete filed (Month, Dey, Year) 32. Registrer's Signature	YIIFE	11114166	-1001. S	
	Registrar	OCT 0 2 2000 Serve & sparks				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland /

Department of Health and Mental	Hygiene	1
Certificate of Death	Reg. No.	0

Physician /Medical Examiner

1. Decedent's Nema (First, Middle, Last) ROY KILGORE BROWN

4a Facility Name (If not institution, give street end number) SACRED HEART HOSPITAL

CUMBERLAND 7. Age (In yrs. last birthdey)

SEPT Month 4b. City, Town, or Location of Deeth

2. Dete of Deeth

24

10:16 A.M. 2000 4c. County of Death

32419

3. Tima of Deeth

1□Yas PNO

Funeral Director

rai", or items 23a or 28a-f ahow Examiner must be notified at

Directo

Funeral

by

Completed

the Meryland

permit. Pages 1 and 2 should be filed within 72 hours effer deat Department of Health end Mental Hygiene. Important: if Nam 27 is marked other than any injury or other trainment.

Physician /Medical

Examiner

physician s the burial

980

page 2

this

deeth.

e Hospital or Attandi n 24 hours after deeth e Funeral Director: A

To the To the To the F

filled in by

completely

Physician/Medical

þ

Completed

Be

Certification: To

edicai

The law requires that the deeth certificate be executed

Box 68760,

Records, P.O.

of Vital

Division or Attanding

215 26 6245 10a State 10b. County

Months 69

If Undar 1 Year | If Under 24 Hrs. Days Hours

ALLEGANY 8. Dete of Birth (Month, Day, Year) NOV 23 1930 9. Birthplace (State or Foreign MARYLAND

Usual Residence of Deceden

5. Social Security Number

10c. City, Town or Location FROSTBURG

10d. Inside City Limits

U.S.

MARYLAND ALLEGANY

10f. Zip Coda 21532 10g. Citizen of What Country?

10e. Street and Number 10613 WASHINGTON HOLLOW ROAD, SW

1 ☐ Never Married 2 ☐ Married

12. Was Decedent Ever in U,S. Armed Forcas? Armed Forces 1 18) Yes 2 No If Yes, Giva KORFAN Yeer or Det 60 NFLICT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Race - Amarican Indian. Bleck, White, etc.

MOM 2□F

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

WHITE 16b. Kind of Business/Industry

Elementary/Secondary (0-12) 10

3 Widowed 4 ☐ Divorced

College (1-4or 5+)

SHIPPING DEPARTMENT

TIRE BUILDING

Specify.

17. Father's Name (First, Middle, Last)

JAMES E. BROWN

FLORENCE KIDDY

18. Mother's Nama (First, Middla, Maidan Sumama)

19a. Informant's Neme/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532 10613 WASHINGTON HOLLOW ROAD, SW, FROSTBURG, MD

BRENDA ATHEY / DAUGHTER

20b. Plece of Disposition (Name of cemetary, cremetory or other plece)

20c. Location - City or Town, Steta

20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify)

FROSTBURG MEMORIAL PARK 9/27/00

FROSTBURG, MD

22. Name end Address of Fecility
SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532

ascular diseaseant gan

26. Placa of Deeth (Check only one)

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition rasulting in death)

cardiac CRREST other U-scleratio

Caldiae disease

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Dua to (or as a consequance of): mellitis

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Miknown 1 Yes 2 No

24a. Was en eutopsy performed?

24b. Wara eutopsy findings aveileble prior to completion of causa of deeth?

1 Yes 24 No 1 ☐ Yes 2 ☐ No

25. Was casa referred to medical examiner? 1 Yes 2 No

Hospitel: Inpatient 5 Pending Investigation

6 ☐ Could not be

28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stata)

29e. Cartifier (Check only one)

27. Mannes of Death

1 Neturel

2 ☐ Accident 3 ☐ Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et tha time, data end pleca, end due to the cause(s) and mennar stelled.

29b. Signature and title of pertifier

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 KENT AVE.,

JOHNSON HEIGHTS MEDICAL BLDG, CUMBERLAND, MD 21502 WILLIAM E. PALIN, M.D.,

State Registrar

31. Deta filed (Month, Day, Year) SEP 2 8 2000

32. Registrar's Signature

A BOTH

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
AMEND# 18 10/4/00 cmh AACO HEALTH DEPT Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death sept. **Physician** 22 2000 Verna C. Blizard 4:15 pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street and number) 4c. County of Death Examiner Anne Arundel Hospital Annapolis Anne Arundel If Undar 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖾 F 139-03-5780 Yrs. 82 Nov 4,1917 Director Pennsylvania Usual Rasidance of Decedant 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Anne Arundel Severna Park Directo "natural", or Items 23s or 25s-f. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? lene.
- then "natural", or items 23s or the Medical Examiner must be 715 Benfield Road 21146 USA Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yes 2 ∑XNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 11 Marital Status 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Maryland 21215-0020 Specify: White ğ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Etementary/Secondary (0-12) Coltege (1-4or 5+) Executive Secretary Campbell Soup Co. 12 I Hygia 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middle, Last) 88 2 should be f and Mental P Frank Croker Emily Thease 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 s nent of Health an Department of Health a important: If then 27 is any injury or other trau phos. . Carol Bishop/Daughter 340 Redwood Grove Court, Millersville, MD 21108 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept 26 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from Steta Lakeview Memorial Park Cinnaminson, NJ 4 ☐ Donation 5 ☐ Other (Specify) 2000 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1 /Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory arrast, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical RESPIRATORY TAILUR Examiner Due to (or as a consequence of Physician/Medical Examiner NEUMON SPIRATIO Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated avents rasulting in death) Last Dua to (or as a consequence of) The law requires that the death certificate be exect Box 68760. been signed by the attending physician should be detached for use as the buria ULMONDRY Due to (or as a consequance of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Wunknown ENENTIB Division of Vital Records. þ 24b. Were autopsy findings available prior to complation of ceuse of death? 24a. Was an autopsy performed? Completed this certificate hes 1 Yes 205 No 1 ☐ Yes 2 ☐ No at or Attending Physician: The state death.

I Director: After this certificated in by the funeral director, pa Be 25. Was cese refarred to medical 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 ☐ Yes > No 1 Sepatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 3903 7 64 Franklin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DS MITCHELL ANNAPOLIS ME AAMC 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State SEP 28 Registrar

SEP 28 2000 pour p forts

Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 321.21

Nh.					Certifica		Death	R	eg. No.		-461	
	Physician	Decedent's Name (First, Middle, I	ast)					2. Date of Dear Month	Day	Year	Time of Death	
	/Medical	SAMUEL BUTL	ER					1	21 2000		3:15 am	
1	Examiner	4a Facility Name (If not institution, g	ive street and number)				4b. City, Town, or L		4c. County			
		808 RICHARD T	ONGUE DRI	VE			MILLERSV			ARUNI		
	Funeral Director	214-50-9943	1 THE	e (In yrs. last bir 2	Yrs. If Uni	der 1 Yeer Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey FEB 2		9. Birthplace Country) MARY	(State or Foreign LAND	
	syand show	Usuat Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location						Inside City Limits	
	or 28e-f st be notified Director	MARYLAND ANNE	ARUNDEL	MILLE	RSVIL	LE		MDXves 2 □ No				
	or 28e-f	10a. Street and Number			10f.	Zip Code		1	0g. Citizen of W	hat Country?		
1		LOOO DEGITADO MO	NGUE DRIV	ľΕ	A 187	2110	8		USA			
020	urs shar doath at, or lisme 23 Examiner must by Funeral	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2X If Yes, Give Year or Detes:				tispento Origin? (Sp an, Maxican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Raca Black Specify:	a - American II k, White, etc. BLA		
21215-0020	ad within 72 ho ypiene. ser then "neture 4, the Medical.	15. Decedent's (Specify only highest of	Education rade completed)	16a.	Decedent's U (Give kind of life, DO NO	work done	during most of work	king	16b. Kind of Bu	siness/Industr	у	
12	Pan Pan	Etementary/Secondery (0-12)	College (1-4or	5+)			0)					
			0		JAN	ITOR	19 Mother's Nam	na (First, Middle, i	BUTLER		TORAL	
Maryland	Mal H									9/		
7	3 Men a Men menta menta To			405		(64		ES NAYL		Ctate Zin Co	(a)	
Ma	S C S C S C S C S C S C S C S C S C S C	19a. Informant's Name/Relationship					end Number or Ru TONGUE		LLERSV		21100	
	Tan The E	JANET W. BUTLE 20a. Method of Disposition	K (MILE)		Disposition (TONGUE		20c. Location -			
0	of H of S	1)☑ Burial 2 ☐ Cremation 3		cemete	ry, crematory o	or other ple				10.20		
altimore	tant: dury	4 Donation 5 Other (Spec			HAVEN			9/25/00			E, MD.	
Bal	Depar Depar any fr ansa	21. Signature of Funeral Service Lic	Leese	MO0482	821	RÉÉSI WEST	ss of Facility E & SONS	MORTU	ARY, P	.A. 21401		
		23a. Pert1. Enter the disease, or co shock, or heart failure. List on	mplications thet cause	the deeth. Do i						Ap	proximete ervat Between	
	Physician /Medical Examiner puruli-transit Examiner E	Immediate Cause (Final disaese or condition resulting in death)	· Ada	Due to (or as a defended of the control of the cont			a une	inour	n y situ		set and Death	
ć	axecu	if any, leeding to immadiate cause. Enter Underlying	Hay	bercal	cem	i'a						
×	phys ss the		c	Due to (or as a o	consequence o	of):						
	death e atten ed for u	Part It. Other significant conditions	contributing to death b	ut not resulting in	n the underlyin	g cause giv	en in Pert I.	23b. Did to	obacco uas cor	tributs to the	cause of death?	
P.0	mat the led by the detache							1 🗆 Y	'es 2□ No	3 Probabl	y 4 Onknown	
	been s should should							24a. Was a perfor	an autopsy med?	availat	autopsy findings ble prior to etion of cause th?	
R	ata hes page 2							1 D Y	es 2 No	1□Y	es 2 No	
	certificata rector, pag						26 Place of Dea	th (Check only or				
Vital	this certific rel director.	examiner?	Hospitel:	ent 2 ER/Ou	Itpatient 3	DOA Oth	or.	ome 5 Presid		er (Specify)		
	rthis erel di		28a. Date of Inju	ry 28b. 7	Time of	28c. tnju		28d. Describe h				
5	To the tropital or attaining Pri within 24 hours after death. Completely filled in by the funeral Medical Certification: "	1 Netural 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide	be 28e. Place of In	ury - At home, fe	mjury M orm, street, fac	1 🗆	Yes 2□No	28f. Location (S City or Tow		er or Rural Ro	oute Number,	
	No Hospital n 24 hours no Funeral pletaty filled		Physician: To the best aminer: On the basis o and menner st	examination an								
	within 2 To the comple					29c. Licens	se number	2	29d. Date aigned	d (Month, Day	Year)	
	- ≱ ⊩ ŏ	1 Man	naum.	0		I	39505		Septer	nber	22,2000	
		30. Name end address of person who	completed cause of c	leath (Item 23a)	(Type, Print)	n fi	my, Gl	en bw	mie,	MD 216	61	
	State	31. Date filed (Month, Day, Year)	32. Regint	ar'a Signature	4	don	1					

home to speak

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SEP 28 2000

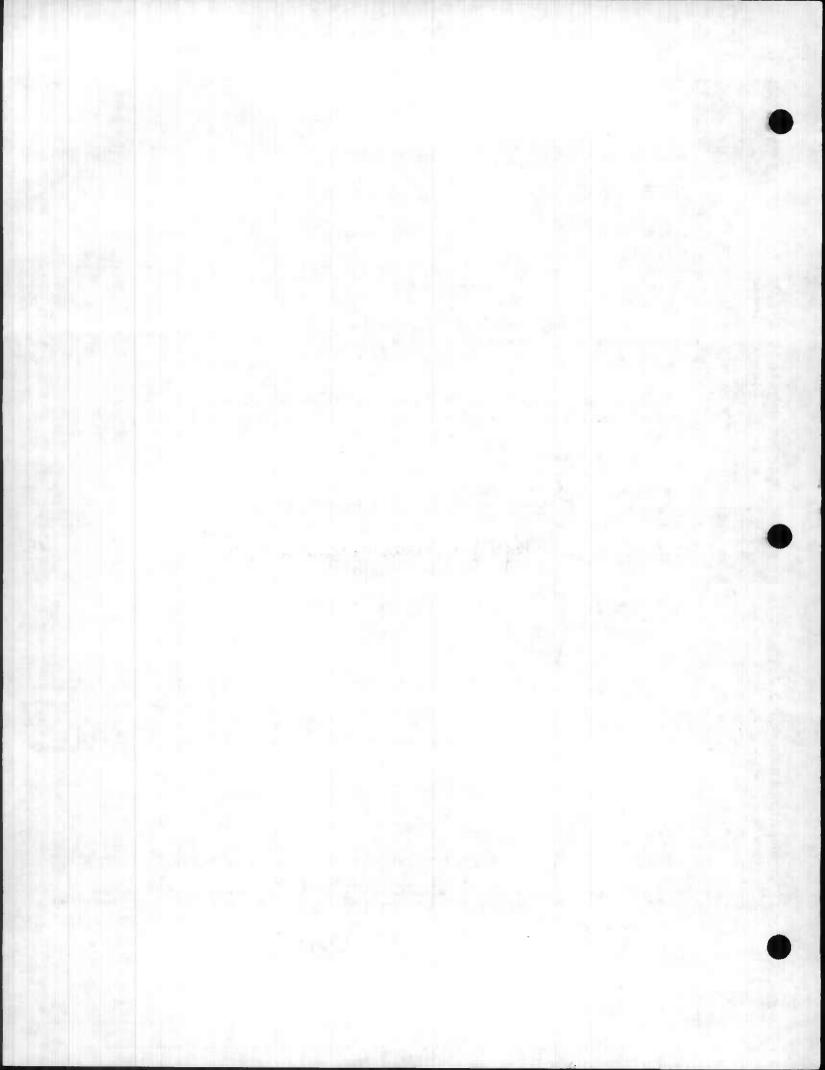
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** October 2000 1350 6 Pearl Martha Butler /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner The Memorial Hospital Talbot Easton If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Yeer) **Funeral** Deys Hours Months 1□ M 25+F Yrs. Director 84 February 22,1916 Indiana 213-14-1985 Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Caroline Denton 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number Herna 23a 24150 Willow Pond Road 21629 United States Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Black, White, etc. traumatic event, the Medical Examiner. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3 ₩ Widowed 4 Divorced Caucasian Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry be filed within 7 al Hygiene. University of Maryland Elementery/Secondary (0-12) College (1-4or 5+) Martha Butler Extension Service Legal Secretary 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be 12 should be fi h and Mental H Is marked of Elmer Joseph Bessie Ann Myers 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) permit. Pages 1 and 2.
Department of Health a Important: If Item 27 Ia any injury or other traconce. 24078 Willow Pond Road, Denton, Maryland Loisann B. Pearsall Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 10/10/00 Denton, Maryland Denton Cemetery 22. Name and Address of Fecility 21. Signature of Funerel Servica Licensee Moore Funeral Home, P.A. bore 23a. Pent1. Enter the disease, for complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate

Approximate Approximete Intervel Between Onset end Deeth Physician Immediate Cause (Final diseese or condition resulting in death) Montes /Medical Examiner Examiner ng physician and as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): certificate be execu Box 68760 Physician/Medicai that initieted events resulting in death) Lest Due to (or es e consequence of): attending 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. been signed by the should be detached 1 Yes 2 TNo 3 Probably 4 Unknown by 24b. Were eutopsy tindings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 2/2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Dinpatient 2 ER/Outpatient 3 DOA Dete of tnjury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 27. Menner of Deeth 28c. Injury et Work? if or Attending P safter death.

Director: After t d in by tha funera 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) 29a. Certifier Medicai end menner steted. 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signeture and title 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) David H. Smith, M.D. 29466 Pintail Drive, Suite 5 & 6, Easton, Maryland 21629 32. Registrar's Signature 31. Dete filed (Mon Day, Year) State 2000 Registra



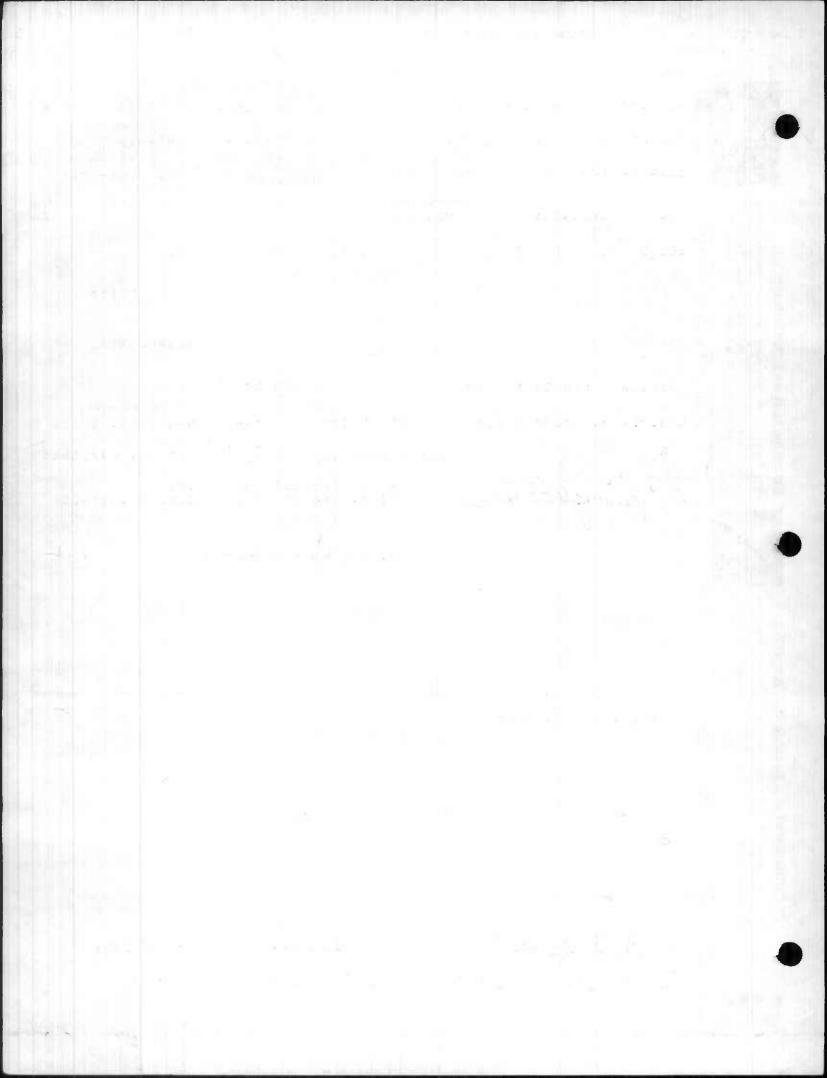
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State of Maryland / Department of Health and Mental Hygiene

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			the transfer		Certifica	ate of	Death		Reg. No.		
Physicia	,	1. Decedent's Name (First, Middle, La	•					2. Dete of De Month	eth Day	Veer	ime of Death
/Medica				lades				Octobe	er 4 20	000 1	:26PM
Examine	er	4a. Fecility Nama (If not institution, giv		0 m a			4b. City, Town, or				
	Щ	Corsica Hills					Centrev		~	Anne	
Funeral Director		5. Social Security Number 221-12-9106 Usuet Residence of Decedent	7. Aga (// 7 / 7 / 7 / 7 / 7 / 7 / 7 / 7 / 7 /	n yrs. last bir 8	Yrs. Month	dar 1 Year hs Days	If Under 24 Hrs Hours Min		y, Year)	9. Birthpleca (Country) Delawa	
ž=		10e. Stete 10b. County	10	c. City, Town	n or Location					10d. In:	side City Limit
the party	to	Md Caroli	ne	Dent	on						JYes 2⊠N
23a or 28	ai Director	10e. Street and Number 10603 Knife B	ox Road			Zip Code 2 1 6 2 9	9		10g. Citizen of V USA	What Country?	
o'.	by Funeral	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Eva Armed Forces? 1 Yes 2 Ano If Yes, Give Year or Dates:	r in U,S.		cedent of F pecify Cuba 2 No	dispanto Origin? (S an, Mexican, Puer Specify:	Specify Yas or No to Rican, etc.)	- 14. Rac Blac Specify	ea - Amarican Ind ck, White, etc. White	lian,
Jical Jical	Completed	15. Decedant's Ed (Specify only highast gra		16a.	Decedent's U	suel Occup	pation	f working 16b. Kind of Busin		usiness/Industry	
Pan .		Elementary/Secondary (0-12)	College (1-4or 5+)				during most of wo d)			naking	
Department of heath and Mentel hygier Important: If teen 27 is marked other trained any injury or other traumatic event, the once. To Be Cor		5		1	abore				MATERIAL CONTRACTOR	·	
	To Be	17. Fether's Name (First, Middle, Last)						ma <i>(First, Middle,</i> Mae Fou		10)	
			11 Blades								
		19e. Informent's Name/Relationship (Alberta A. Bla					end Number or R				
	-	20e. Method of Disposition			Disposition (/		e Box R	1		City or Town, S	. 6 2 9
		1 M Buriel 2 ☐ Crametion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specification)	Removel from Stata	cameter	on Cer	metel	ry	0ctate 7 2000	Denton	, Mary	
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		23a. Part1. Enter the disease or company shock, or hourt failure. List only	plications that caused the	death. Do r	not enter the m	node of dyir	ng, such as cardia	c or raspiratory e	rrest,	Appro	oximeta vet Between
Medical aminer	iner	Immediate Cause (Finel disases or condition resulting in death)	e	e to (or es e	consequence		restin	teutim			wh
	Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury c.									
O 6	Medical	resulting in death) Lest Due to (or es e consequenca of):									
tendii or use	Physician/		d							1	
the elf	SIC	Part II. Other significent conditions of	ontributing to death but n	ot resulting in	the underlyin	g causa giv	ven in Pert I.	23b. Dld	tobecco use co	ntribute to the c	ause of death
signed by the ettendir	by Phy	Alshiner D	encution					10	Yes 2□ No	3 Probably	4) Hnknov
should	Completed								en eutopsy rmed?	24b. Were eu availabla completi of deeth	prior to on of cause
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iffica lor, p	Bec	25. Was case referred to medical					26. Place of De	eth (Check only o			
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is certificate he director, page		27. Manner of Death	28e. Dete of Injury (Month, Dey Ye		Tima of	28c. Injur			now injury occur		
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in 24 hours effer death. Ne Funeral Director: After this pletely filled in by the funeral di	edical Certification:	1	28e. Plece of Injury building, etc. (5	pecify) y knowledge	rm, street, fact , deeth occurr d/or investigeti	ed et the tir ion, in my d 29c. Licens	opinion, deeth occi	City or Tow e, end due to the urred et the time,	ceuse(s) end me date end pleca, 29d. Dete signe	enner es steted. end due to the c	euse(s)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended State of Maryland / Department of Health and Mental Hygiene Line 3./WCHD/SC Certificate of Death October 3, 2000 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** Joan Marie GOUKER October 2, 2000 /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington 9620 June Avenue Hagerstown If Under 24 Hrs. Hours Min. If Under 1 Yeer 5 Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Deys Hours 1 M 2 K 086-40-0785 52 Director May 25, 1948 New York Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Name 23s or 28s-f show 1 Yes 2 No il Hygiene, other then "neturel", or lleme 33e or 28e-f. Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 9620 June Avenue 21740 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) t4. Raca - American Indien, Bleck, White, etc. 11. Merital Stetus 72 hours after 1 Never Merried 2K Married Maryland 21215-0020 white 1 Yes 2₺ No Specify: by 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within Elementery/Secondery (0-12) Cotlege (1-4or 5+) beverage distributor draft technition 12 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) ed bluods Mental Grace Marie Santoro James L. Comer is marked 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Bnd 19a. Informant's Neme/Reletionship (Type, Print) Pages 1 and 2 9620 June Ave., Hagerstown, Maryland 21740 Robert L. Gouker - husband Department of Health Important: If Nem 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete ò 10-4-00 Hagerstown, Maryland any injury 4 Donetion 5 Dother (Specify) Rose Hill Cemetery 22. Name end Address of Fecility MINNICH FUNERAL HOME 415 E. Wilson Boulevard, Hagerstown, Md. 21740 Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final 0 disease or condition resulting in death) Examiner Due to (or es a consequence of) Physician/Medical Examiner The lew requires that the death certificate be axecuted use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): and 68760 the attending physicien Due to (or es e consequence of) Box P.O. 23b. Did tobacco use contribute to the cause of death? deteched Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2 No 3 Probably 4 Unknown s certificate has been signed by director, page 2 should be detec 1 Yee p Division of Vital Records, 24b. Were autopsy findings eveilable prior to completion of cause of death? Be Completed 24e. Wes en eutopsy performed? 2 NO NO 1 □ Yes 2 □ No 1 ☐ Yes Physician: 25. Wes case referred to medical 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home Medicai Certification: To 1 Yes Residence 6 Other (Specify) nours after deeth.

neral Diractor: After this filled in by the funeral di Menner of De 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? or Attanding P Neturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 26e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) 29e, Certifier (Check only one) end manner steted 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 31. Dete filed (Month, Day, Year)

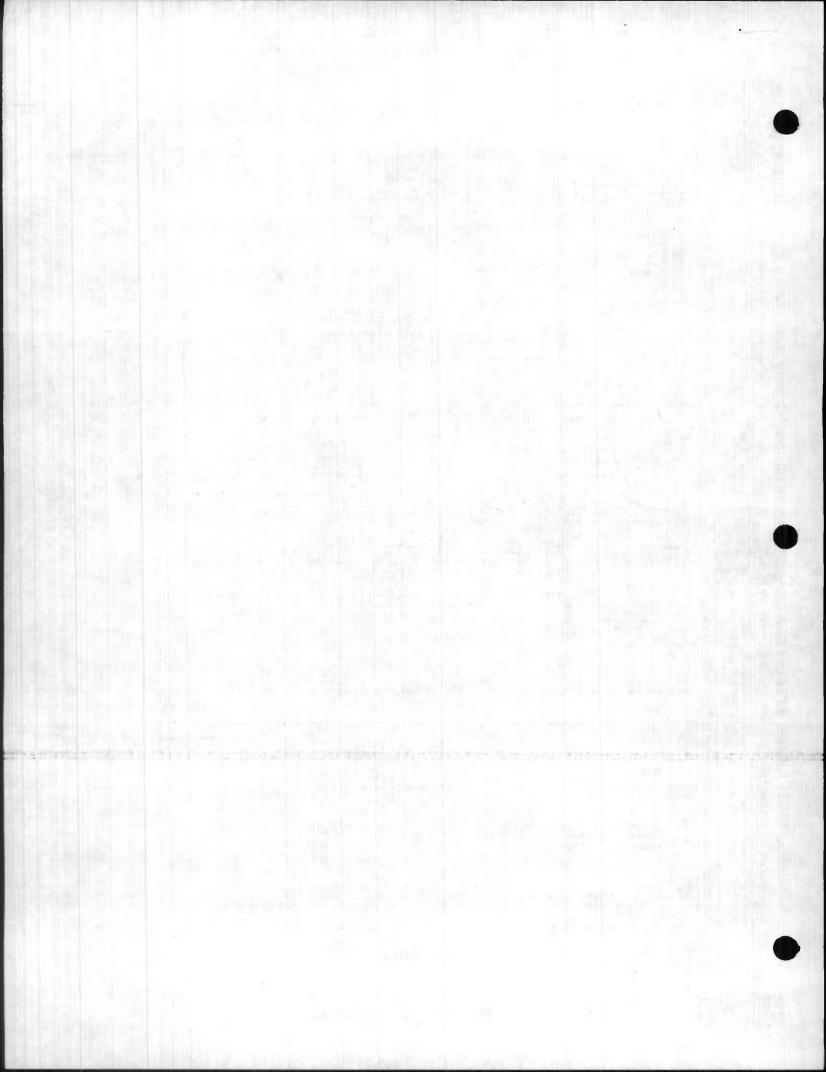
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State

Registrar

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	Certificate of Death		Reg. No.	32425
Dhusisian	Decedent's Neme (First, Middle, Last)	2. Dete of De		3. Time of Death
Physician /Medical	Susie Lucinda Cox	9	29 20	000 11:14
Examiner	4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Memorial Hospital Cumberla	and	h 4c. County o	Allegany
Funeral Director	5. Sociel Security Number 218-52-2807 G. Sex T. Age (In yrs. lest birthdey) 1 M 2F F 95 Yrs. G. Sex Months Deys Hours Min		1905	Birthplece (State or Fore Country) WV
P Au	10e. State 10b. County 10c. City, Town or Location			10d. Inside City Lim
Maryla Had at for	WV Mineral Wiley Ford			1□Yes PÐ
of the Ma	10e. Street and Number 10f. Zip Code		10g. Citizen of W	hat Country?
	Route 1 Box 55 26767		USA	
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ontal Hygiene. Ned other than "nature is event, the Medical. O Be Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo	rking	16b. Kind of Bus	siness/Industry
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Co Harris	12 homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Ne	me /First Middle	, Maiden Sumeme	
Be eve	George Seymour Baldwin Mary A	(Abe)	, maidon comonic	,
M bd M	19e. Informent's Neme/Reletionship (Type, Print) James Cox 19b. Meiling Address (Street and Number or Reletionship (Type, Print)) Route 1 Box 55; Wile	ural Route Numb	per, City or Town, S	State, Zip Code)
mil. Pages 1 and 2 partment of Health a portant: if hen 27 is y injury or other trauch.	20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 4 Donetion 5 Other (Specify) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Abe Cemetery	10/02 2000		City or Town, State Gap, WV
Departiment of the control of the co	21. Signeture of Funeral Service Licensee Scarpedings of Facilities Cumberland, MD		ne, P.A.	
	23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdia shock, or heart feilure. List only only cause on each line.	c or respiretory a	arrest,	Approximete Interval Between
Attending Physician: The law requires that the death certificate be executed a redeath. For death. For death. For this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit if iffication: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, it erry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
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or Attend after death Director: A I in by the f	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)		(Street end Number own, State)	er or Rural Route Number,
To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors. Medical Certification: To Medical Certification: To	29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place (Check only one) Certifying Physician: To the best of examination and/or Investigation, In my opinion, deeth occurred at the time, date and place (Check only one)			
within To the comp	29b. Signeture end title d'on les 29c. License number		29d. Dete signed	(Month, Dey, Year)
	1 D003328	0	Sept 2	9 2000
67	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)			,
~	SUNIL K., GUPTA, JOHNSON HEIGHTS MEDICAL BLDG., 625 K	ENT AVE.	, CUMBER	LAND, MD 21
State	31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signeture			
Registrar	OCT 0 3 2000 Server & Sparks			



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Day Month **Physician** October 1, 2000 20:15 Daniel Hetic Cooper /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Memorial Hospital & Medical Center Cumberland Allegany if Undar 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplaca (Stata or Foreign Country) **Funeral** 12 M 2□ F Months 83 West Virginia 214-07-4585 Director April 10, 1917 Usual Residence of Decedant the Marylend 10a. Stata 10b. County 10c. City, Town or Location al Hygiene. other than "natural", or fiams 23a or 28a-f show ivent, the Medical Exeminer must be notified at 10d. Insida City Limits 1 Yas 2 No Director Cumberland Maryland Allegany 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? Peges 1 and 2 should be filed within 72 hours after death with neit of Healith and Mental Hyglens.

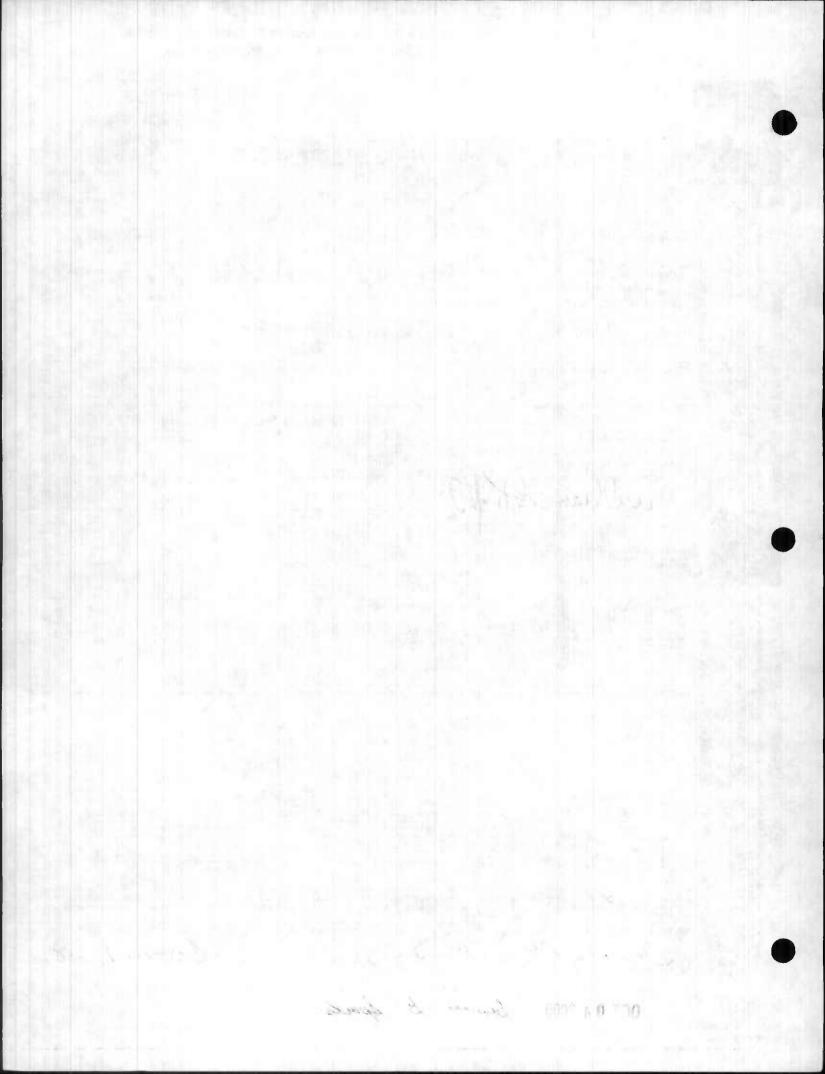
It is hem 27 is marked other than "natural; or itams 23a or ury or other thaumatic avent, in Medical Exercises marks in ury or other traumatic avent, in Medical Exercises marks in the second of th 322 Davidson Street 21502 **USA** Funeral 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Dates: 1943-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 11. Marital Status 14 Rece - American Indian Black, Whita, atc. 1 Nevar Merried 2 Married Baitimore, Maryland 21215-0020 1 Yas 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Trucker Textile Co. 10 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Wilbur C. Cooper Hattie (Royce) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Hilda C. Cooper 322 Davidson Street, Cumberland, MD 21502 20b. Placa of Disposition (Nama of cematary, cremetory or other place)
Sunset Memorial Park 20e. Mathod of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 20c. Location - City or Town, State permit. Peges Department of Important: If It any Injury or o 4 ☐ Donation 5 ☐ Othar (Specify) 10/5/00 Cumberland, MD 21502 22. Name and Address of Facility Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502 Approximata Intarval Batween Onsat and Deeth 23a. Part1. Entar tha disaasa, or complications that caushock, or haart tailure. List only one cause on each tha death. Do not antar the mode of dying, such as cardiac or respiretory arrest, **Physician** Immediata Cause (Final diseese or condition rasulting in death) /Medical 20 minutes Cardiac Arrhythmia Examiner Due to (or es e consaguance of) Physician/Medical Examiner Coronary Heart Disease years anding physician and use as the bunal-transit The law requires that the death certificata be axecuted Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Ceuse (Disease or injury that initiated evants resulting in death) Last Dua to (or es a consequance ot): P.O. Box 68760. Atherosclerosis years Due to (or as e consequence of): Part II. Other eigniffcant conditions contributing to death but not rasulting in tha undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2□ No 3 Probably 4 Unknown Hypertension, Pneumonia, Lung Cancer as been signed 2 should be de Division of VItal Records. þ 24b. Were autopsy findings available prior to complation of causa of death? Be Completed 24a. Was an autopsy performed? eged 1 Yas 2 No 1 Yas 2 No certificate or Attending Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No Medical Certification: To After this 28c. Injury at Work? 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 5 Panding invastigation 1 Netural Injury aftar deeth. 1 Yes 2 No 2 Accident 6 Could not be datarmined 3 Suicide 28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D completaly filled I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) 29b. Signature and titla of certifian 29c. Licensa number 29d. Deta signed (Month, Day, Year)

Dr. Beverly M. Calkins 500 Memorial . Registrer's Signatura

30. Nama and address of purson who complated causa of death (Item 23a) (Type, Print)

Avenue #105 Cumberland, MD sporks

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Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

from to Amode

SEP 28 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) Day :15 Pm **Physician** Nancy Lee Collins September25 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hrundel Hespi 8. Data of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) 5. Social Sacurity Number **Funeral** Months Days Hours 1 M 2 TF Yrs. 208-32-4472 March 25 1941 Pennsylvania Director Usual Rasidence of Decedant COLLINS, 72 hours efter death with the Maryland 10d Insida City Limits 10a Stata 10h Counts 10c. City. Town or Location traumstic event, the Medical Examiner must be notified at MD Anne Arundel Arnold 1 Yas 2 No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? Harrie 23a or 1280 Double Day Drive 21012 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decadant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yas, Giva Year or Datas: 14. Raca - Amarican Indian, 11. Marital Status Black, White, atc 1 Nevar Married 2 X Married 1 ☐ Yas 2 ☐ No White Maryland 21215-0020 "naturel", or Specify Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada complated) el Hygiene. Elamentary/Secondery (0-12) 12 Collega (1-4or 5+) Home Homemaker 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be 2 should be fi end Mentel I is marked of William Kephart Nellie Somers 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Pages 1 and 2 s ment of Heelth en Joseph Collins/Husband 1280 Double Day Drive, Arnold, MD 21012 Department of Heelth Important: If Item 27 I altimore, other 20b. Placa of Disposition (Nama of cematery, cramatory or other placa) 20c. Location - City or Town, Stata Data 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial Gardens Sept 28 9 Davidsonville, MD eny Injury 2000 22. Nama and Address of Facility Barranco & Sons, P.A. Severna Park FuneralHome 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Papil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onsat and Daath **Physician** immediata Causa (Final disaasa or condition resulting in deeth) /Medical miner Physician/Medical Examiner 7 U The lew requires that the deeth certificate be asscuted Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Diseese or injury that initiated evants resulting in death) Last use as the burial-tran Box 68760, Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Wara autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy parformed? director, page 2 should Medical Certification: To Be Completed certificata hes 2 0 NO 1 Yes 2 No 1 🗆 Yas or Attending Physician: 25. Was casa rafarred to medical examinar? 26. Piece of Death (Check only ona) 1 Yes 2 No Hospital: 1 € Inpatiant 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 28a. Date of Injury (Month, Dey Year) the funaral 27. Mannar of Death 1 Di Natural 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation after death. 1 Yes 2 No 2 Accident 8 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 3 ☐ Suicida in by t Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 T Homicida To the Hospital within 24 hours a 29a. Cartifier To Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated compietely 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 31. Data filed (Month, Day, Year) **SEP 27**

29b. Signature and titla of certifier

32. Ragistrar's Signature Dener

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30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print)

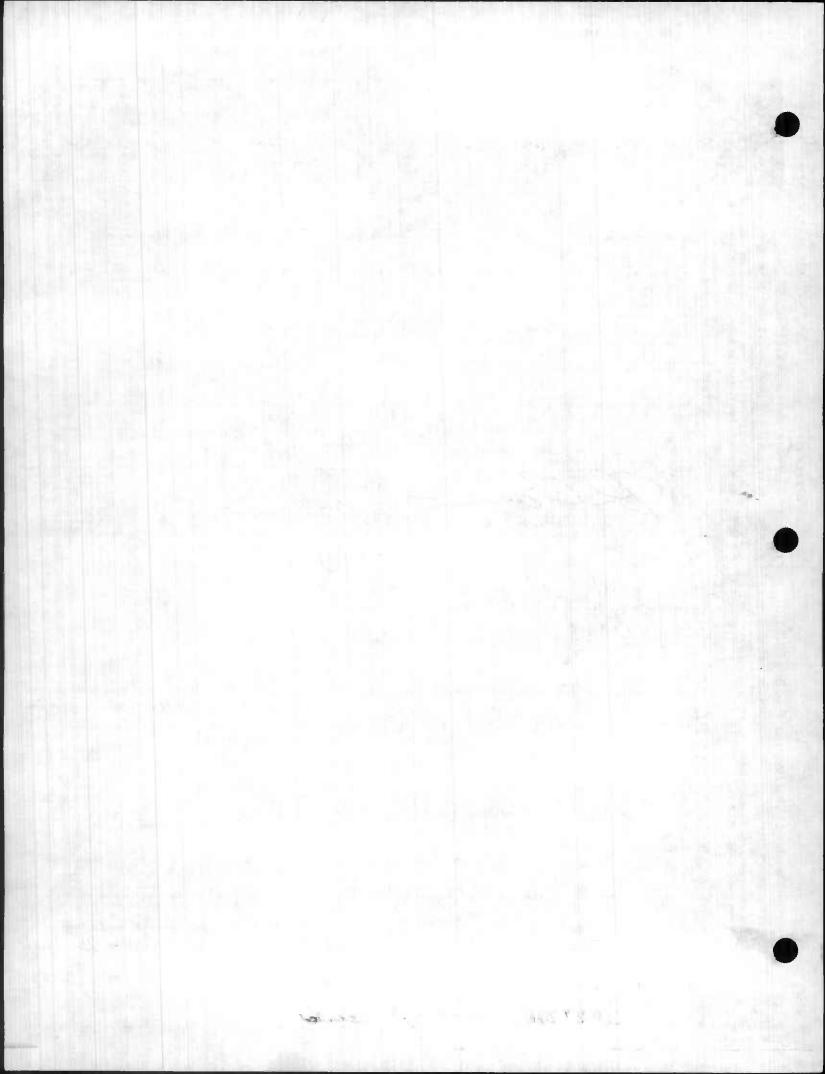
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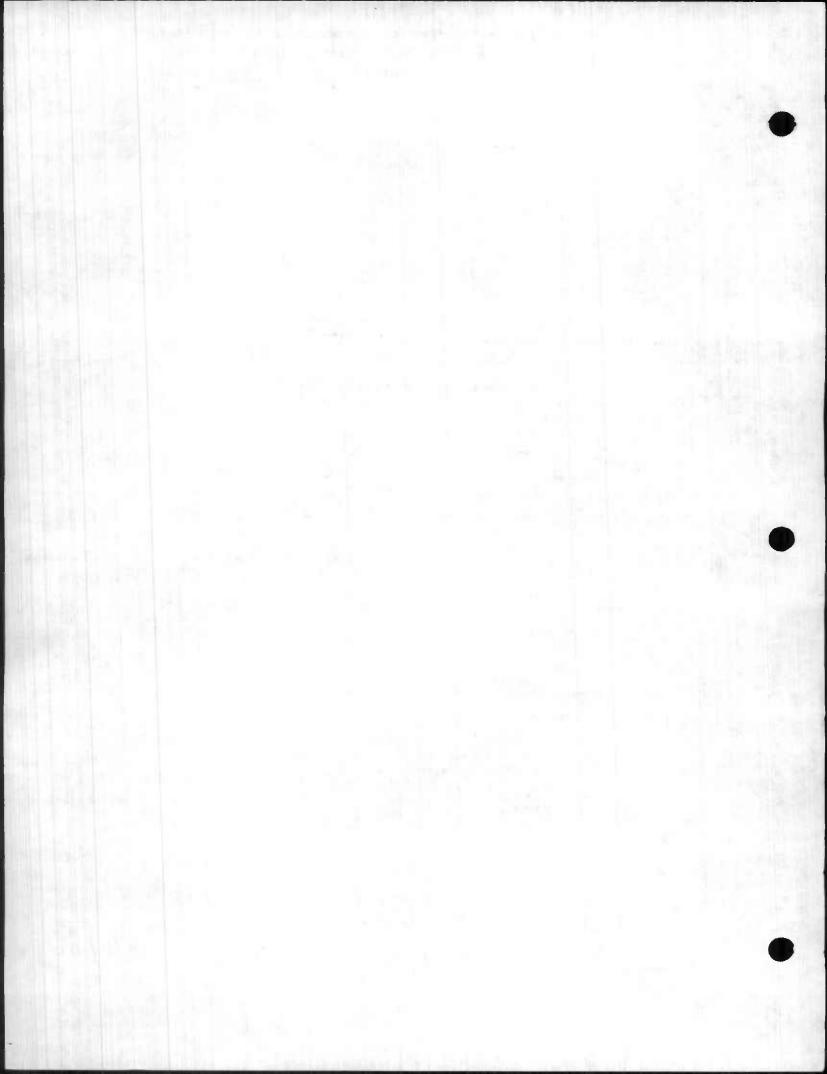
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State of Maryland / Department of Health and Mental Hygiene

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Baltim permit. Pa Departmen important: any injury	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom-Hawkins PO Box 43, Feder 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of									OW	Funer	al	lome,	PA
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death death death d for	icia	Part II. Other significant conditions of	ontributing to death but	not resu	Iting in the unc	derlying	cause give	n in Pert I.	23b.	Did toba	cco uas co	ntributs to	the cause of	of death?
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		30. Name and address of person who	completed cause of de	ath (Item	23a) (Type, P	rint)	1)	(123	-			0 10	100	
		Mary DeShield					d Av	e F	aston,	MD	2160) 1		
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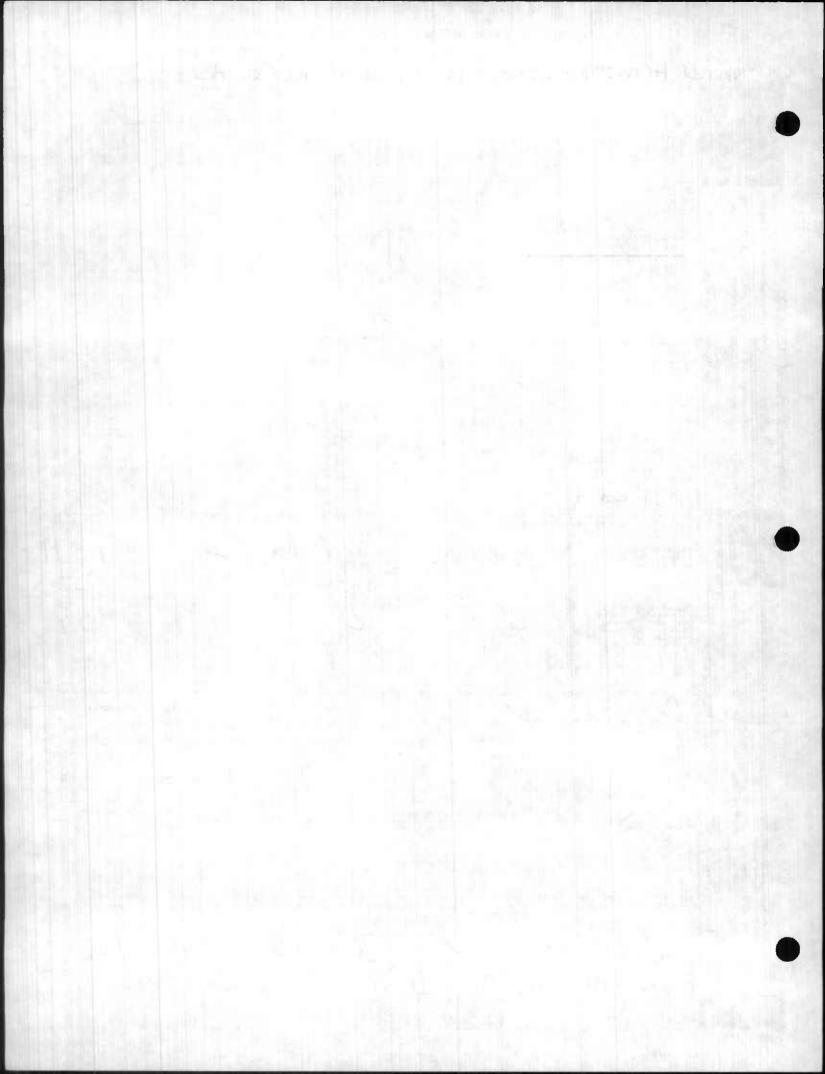


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10600. Der figertificate of Death Co. 2. Date of Death 3. Time of Death October 1, **Physician** DAVID ROBERT CRANDELL 2000 1215 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 310 Park Avenue Federalsburg Caroline If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (Stata or Foreign Country) Funeral 1 M 2 □ F Months Days 213-62-2706 47 Yrs. Jan.21,1953 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at MD Caroline Federalsburg 1 WYes 2 □ No Director 100. Street and Number Avenue 310 Park Avenue 10f. Zip Code 10g. Citizen of What Country? 21632 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? NO Yes 2 □ No If Yes, Giva Year or Dates: 1 7 0 - 7 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes X□ No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) then. Elementary/Secondary (0-12) College (1-4or 5+) Food Service Hygiene. Restaurant Cook 10 end Mentel Hygin 18. Mother's Name (First, Middla, Maidan Surnama) 17. Father's Name (First, Middla, Last) Pages 1 and 2 should be Sally Marie Elzey Donald Charleston Crandell, Sr. 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Joyce A. Crandell/Spouse 310 Park Ave., Federalsburg, MD 21632 Mam 27 I 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If Its any Injury or o 6 1 Burial 2 Cremation 3 Removal from State Hurlock, Maryland 10/4 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery Framptom-Hawkins-Eskow Funeral Home, PO Box 43, Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Ecken Muhad 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each lina. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition rasulting in death) Examiner Physician/Medical Examiner The lew requires that the death certificate be asscuted signed by the attending physician and dbe detached for use as the burial-tran Sequentially list conditiona, if any, laading to Immediate cause. Enter Underlying Cause (Disaase or injury Box 68760, that initiated evants resulting in death) Last Due to (or as a consequence of): P.O. 23h. Did tobacco use contribute to the cause of death? Part IL Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy pege 2 1 Yes 2 No 1 Yas certificate septel or Attending Physician: The hours after deeth.
Inexal Director: After this certificate y filled in by the funerel director, pe 25. Was case referred to medical Be 26. Placa of Daath (Chack only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No 10 5 Rasidance 6 Other (Specify) 27. Mangar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida within 24 hours a To the Funeral C the Hospital Decrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier completaly (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

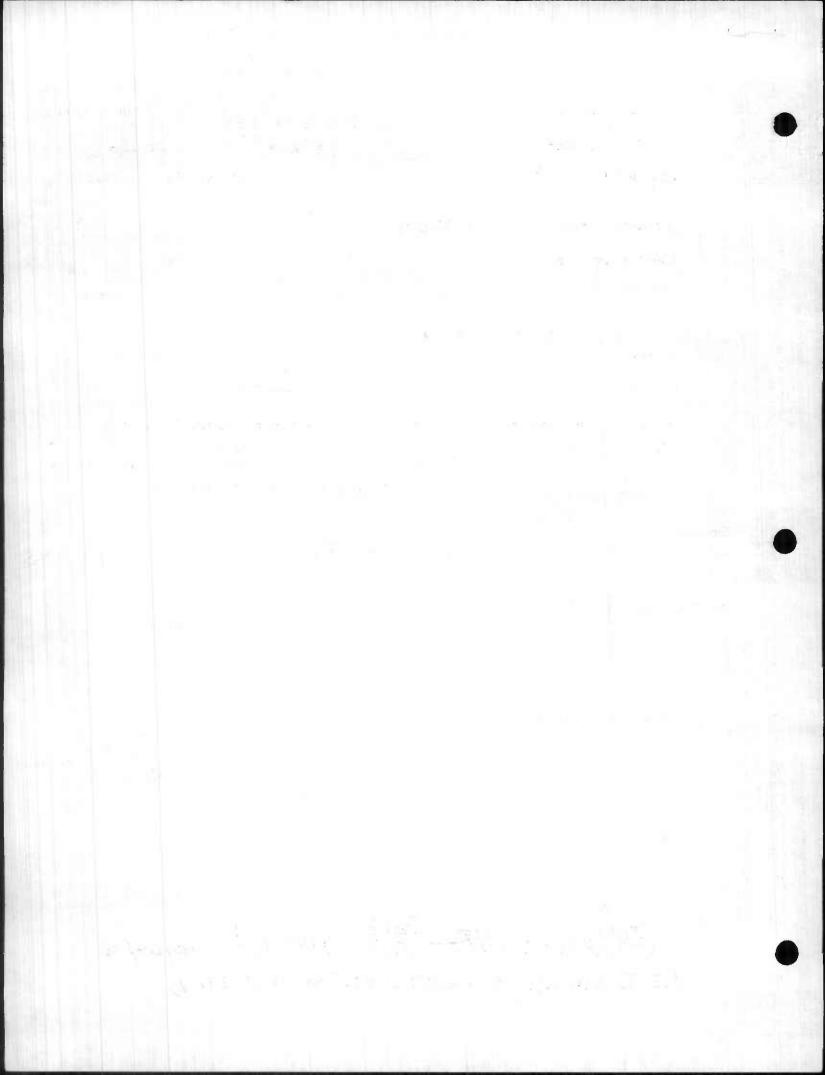
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Registrar



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** OTIS COBB 2035 October 4 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner The Memorial Hospital Talbot If Under 1 Year 9. Birthplace (State or Foreign Country)
N. Carolina 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 € M 2 □ F Months Days Hours Min. 78 Yrs. Mar. 22, 1922 N. 243-38-9732 Director Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits w 23s or 28s-f show must be notified at 1 ☐ Yes 2 ☑ No Preston Caroline Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21655 United States P.O. Box 63 'natural', or items 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Types 2 No
If Yes, Give
Year or Dates: 1 41 - 45 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Black à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiane. other than "p Elemantary/Secondary (0-12) Collega (1-4or 5+) Caroline County Public Works/ Roads 10 permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy important: If hear 27 is marked other any Injury or other to 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Dock Cobb Lillie Bryant 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PO Box 63, Preston, MD 21655 Ida Louise Cobb/Spouse 20b. Place of Disposition (Neme of cemetary, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 \(\mathbb{R}\) Burial 2 \(\mathbb{C}\) Cremation 3 \(\mathbb{R}\) Removal from State 4 \(\mathbb{D}\) Donetion 5 \(\mathbb{O}\) thar (Specify) Hurlock, Maryland 10/10 Veterans Cemetery 22. Name and Address of Facility
Framptom-Hawkins-Eskow Funeral Home, PA 4skow PO Box 43, Federalsburg, Md 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervat Betw Onset and Death Physician Immediate Cause (Final disease or condition resulting in daath) /Medical one da Examiner Examiner one do Sequentially list conditions, if any, laading to immediate ceusa. Enter Undarlying Cause (Disaase or Injury that initiated events resulting in death) Last attending physician and for use as the burial-trans certificate be execu Leons severe COPD Box 68760 Physician/Medical Due to (or as a consequence of) Leous dereare corowary artery P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown yd bengis Division of Vitai Records. q 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Be Completed page 2 has 1 Yes 2 200 1 ☐ Yes 2 ☐ No certificata 25. Was case referred to medical 28. Placa of Daath (Chack only ona) Hospital: 1 Appatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To After this 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred edical Certification: s after death.

Joinector: Attent
of in by the funera 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital o within 24 hours at To the Funeral Ol **Descripting Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5/00. 046020 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Ave., Easton, MD 21601 506 Idlewild Syed Ali,

DHMH 16 Rev 6/95

State

Registrar

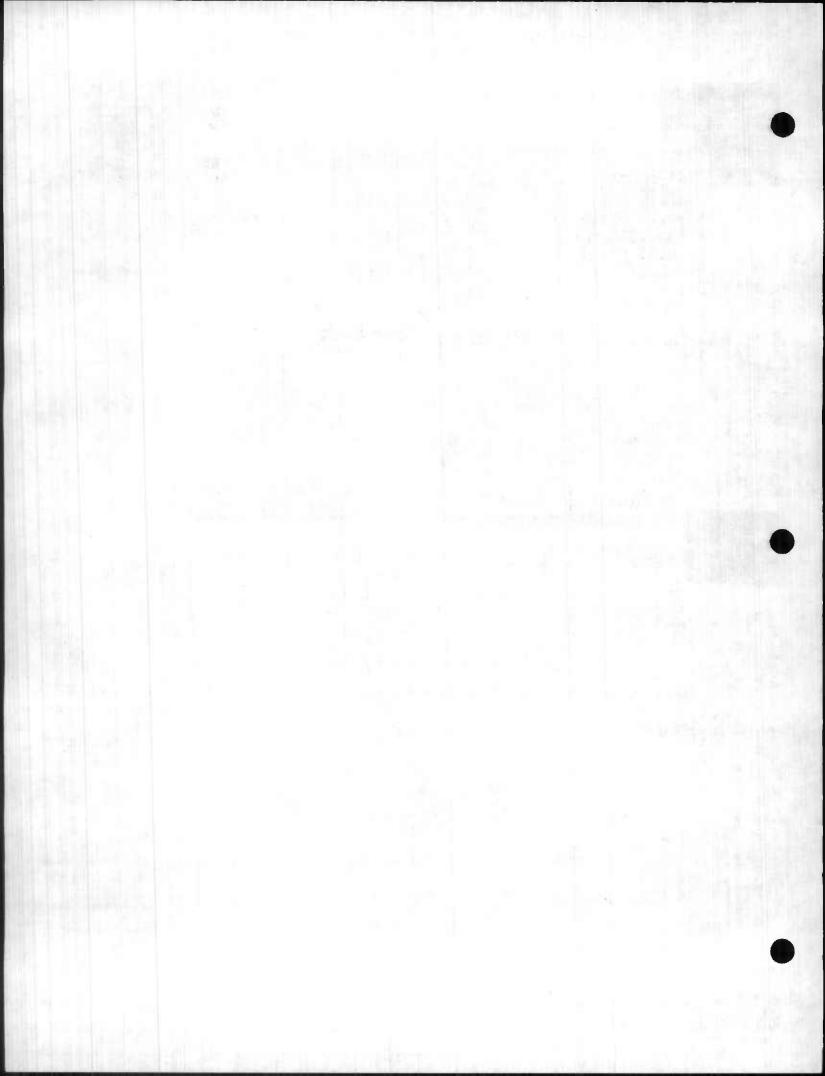
31. Date filed (Month, Day, Year)

DCT 6 6 2000

oaks

32. Registrar's Signature

Reperone



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth Sept. 2 gay 2000 6:44 a.m John Stanton Dovle 4e. Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Homewood Retirement Center Williamsport Washington | H Under 1 Yeer | H Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year) | Min. | March 20, 1919 9. Birthplece (State or Foreign Country) New York 5. Social Security Number 7. Aga (In yrs. last birthday) 1 M 2 F Yrs 062-12-9712 Usuel Residence of Decedent 10d. Inside City Limits 10e. Stete 10b. County 10c. City, Town or Location 1 Yes 2 No W. Virginia Jefferson Harpers Ferry 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? Route # Box 618 25425 USA 14. Race - American Indian, Bieck, White, etc. 12. Was Decedent Ever In U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yas or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Yaar or Dates: 1 Never Merried 2 Married 1□ Yas 2☑ No White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Quality Assurance Statistician U. S. Government 17. Father's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Meiden Surneme) John Stanton Doyle Florence Barrett 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Sandra J. Doyle Wife Rt. 2 Box 618 Harpers Ferry, W. Virginia 25425 20b. Piece of Disposition (Neme of cematery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 X Cremetion 3 ☐ Ramoval from Steta 10/2/00 Hagerstown, Maryland Hagerstown Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Gerald N. Minnich 305 N. Potomac Street 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, Approximate Street Hagerstown, Maryland 21740 Approximate street Approximate str Lousderdore immediate Cause (Final disaesa or condition resulting in deeth) Due to (or as e consequence ot): Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence ot): Due to (or as a consequenca ot): Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown 1 Yes 2 No 24b. Were autopsy tindings eveileble prior to completion of cause of death? 24a. Wes en autopsy performed? 210 No 1 ☐ Yes 2 ☐ No referred to medical 26. Pleca of Deeth (Check only one) Hospitai: Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28e. Dete of tnjury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturai 2 Accidant

attending physician end for use es the burial-transit To the Hospital or Attending Phys within 24 hours efter deeth. To the Funeral Director: After this funeral

Physician/Medical þ Be Completed 2

Examine

Physician

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Examiner

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r than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at

filed with Hygiene.

Department of Health and Mental is Important: If Item 27 is marked off any injury or other to

Physician

/Medical

Examiner

Certification:

Medical

3 ☐ Suicide 4 Homicide 29a, Certifier

(Check only one)

6 Could not be determined

OCT 0 2 2000

5 Pending Investigation

28e. Pleca of injury - At home, term, street, fectory, office bullding, etc. (Specify)

32. Registrer's Signeture

1 Yas 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end pieca, and due to the cause(s) and menner steted.

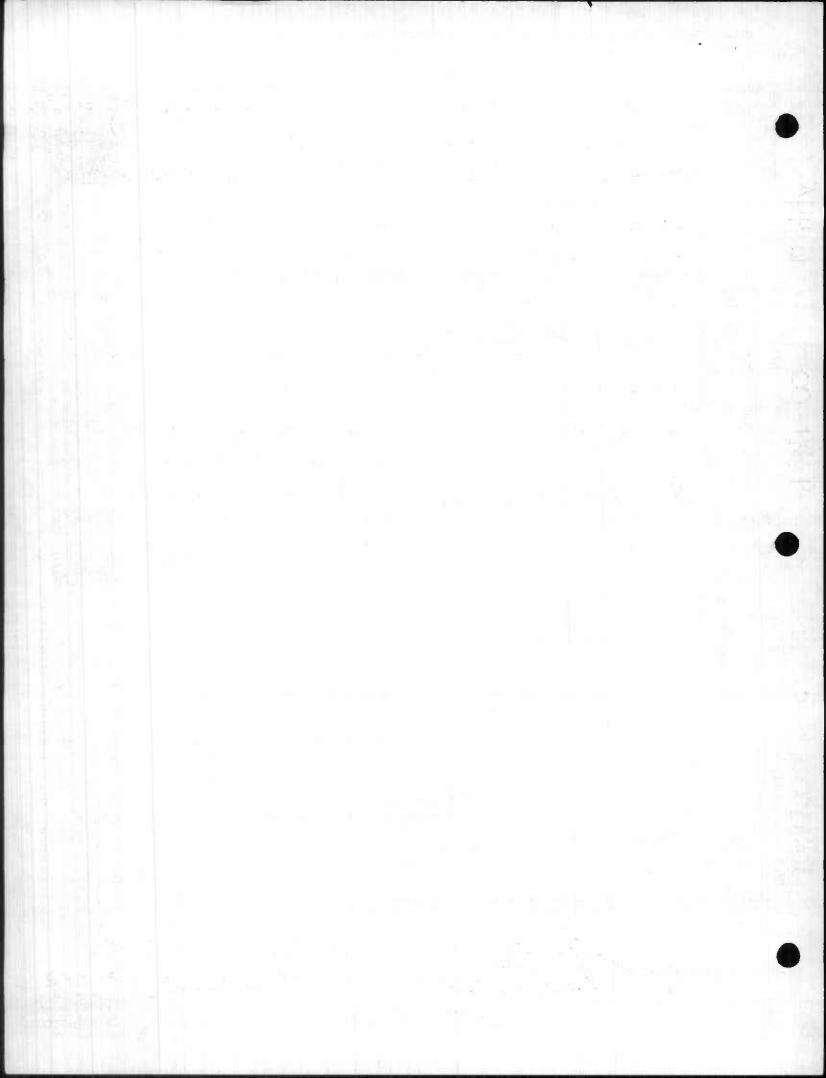
29b. Signature and title of certific

26806

of deeth (Item 23a) (Type, Print)

Kagos Xon as 21>42

State Registrar



Physicia /Medic Examin

Funeral Director

MLU	Please		Print In B						_	ible.	
		State	of Maryland		rtment of tificate of				giene Reg. No.	00	32434
1. Decedent's Name (F	irst, Middle, L	ast)	751	E CONT				2. Dete of Dea			3. Time of Death
Ora Joe Do								Month		Yeer 000	10:50 PM
4a Facility Name (If no	ot institution, g	ive street and nu	imber)			4b. City, To	wn, or L	ocation of Death	4c. Coun	ty of Deet	h
10013 Deist I	Lane, N.	N.				Frostbu	ra		Alieg	any	
5. Social Security Num 234-52-6113	ber 6.	Sex 10 M 2□ F	7. Age (In yrs. la	st birthday) Yrs.	Months Deys	r If Undar		8. Dete of Birt (Month, De	y, Year)	Co	hplaca (State or Foreign buntry) † Virginia
Usual Residence of De			00					16-May-	33	4462	i viigiiliu
	0b. County		10c. City	Town or Loc	cation						10d. Inside City Limits
Maryland	Alleg	anv	Frosti								1 ☐ Yes 2 No
10e. Street and Number	er e	Delst Lane		Juig	10f. Zip Code		H		10g. Citizen of	Whet Co	untry?
		1			21532-				U.S.A.		
11. Marital Status		Armed Fe		5. 13. V	Ves Decedent of Yes, specify Cu	Hispanic Ori ban, Mexicar	gin? (Sp n, Puerto	ecity Yas or No- Rican, etc.)		ace - Ama eck, White	rican Indian, e, etc.
1 Never Married 3 Widowed 4	10	1 V Yas If Pes, Gi Year or D	2 No ive Detes: 1/je t/	1	☐ Yes 2 No					//////////////////////////////////////	
(Specify	1	rade completed)		16a. Deced	ent's Usuel Occu kind of work done O NOT use retir	e during mos	t of work	ing	16b. Kind of		Industry
Elementary/Seconda	iry (0-12)		1-4or 5+)	House	keeping s	unervis	or		bosnital		
12	-A ##-4#- 1	0		110036	reebing 3	1			hospital		
17. Father's Name (Fir:	st, Mickille, Las	4)				18. Mothe	ers Nem	e (First, Middle,	Maiden Sume	me)	
Allan Darby						Tiida	Carte	er			
19a. Informent's Name	/Relationship	(Type, Print)		19b. Mailin	Address (Stree	et and Numb	er or Rui	ral Route Numbe	er, City or Tow	n, Stete, 2	(ip Code)
Nora "Kitty" [arby	wife			Deist Lane,	N.W.	Fro	stburg /	Maryland	t	21532-
20a. Method of Disposi 1 Burial 2 C 4 Donation 5 [remetion 3 (Stete	metery, crem	sition (Name of etory or other pl morial Park	ece)	0.	Dete 4-Oct-00	20c. Location		
21. Signature of Funer	al Service Lice	Insee Con	ust		Name and Add			Frost Ave.	Frostbur	g, MD	21532
23a. Part Lenter the control of the	disease, or con piture. List only	nplications that of one cause on o	caused the death.	Do not ente	r the mode of dy	ring, such as	cardiec	or respiretory er	rest,	1	Approximete Interval Between Onset end Death
Immediate Cause (Findisease or condition resulting in death)	al	· E	xane	vin	ation		16			!	12 hour
		Me	Due to or	as e consequ		tert in	al	Headi	US	1	12 400
Sequentially list conditi if any, leading to imme cause. Enter Underlying	diate	Seven	Dye to (or	as a consequ	rolled oil.			hrow	+ You	.cll	1) 84
Cause (Disease or inju that initiated events resulting in death) Last		· Mv	Pue to (or lible	as a consequence My		Esta	Sfer	re by	Agent	Or	augo) 27
Part II. Other significar	nt conditions	contributing to d	eath but not resul	ting in the un	deriving cause of	iven in Part I		23b. Dld 1	obacco use o	ontribute	to the cause of death?
Chanic	Ost	votive	, /	rg	disea	50		10	2/		robably 4 Unknown
			XIII	7			<u>L</u>		en eutopsy rmed?		Were autopsy findings eveilable prior to completion of cause of death?
										1	or wealth:

Physician /Medical Examiner

permit. Pages 1 and 2 abouid be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens. Important: if ham 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumstic avant, the Medical Examinar must be notified at once.

Baitimore, Maryland 21215-0020

Be Corr 25. Was cese referred to medical examiner? examiner?
1 | Yes 25 No

27. Manner of Death
1 | Naturat 5 Medical Certification: To

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Puneral Director: After this certificate has been signed by the attending physician and complishing tilled in by the tunness director, page 2 should be deteched for use as the build-iransit complishing tilled in by the tunness director, page 2 should be deteched for use as the build-iransit Division of Vital Records, P.O. Box 68760,

CARI State

Registrar

3 Suicide

29a, Cartifier (Check only one)

4 Homicide

29b. Signature and title of pa

31. Date filed (Month, Day, Year) OCT 0 3 2000 0

1 Inpatient - CATOutpatient 3 DOA

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of Injury

29c. License number 13601

28c. Injury at Work?

Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

29d. Data signed, (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 ☐ Yes 2 No

1 Yes 2 No

26. Placa of Deeth (Check only one)

Other: 4 Nursing Home Residence 6 Other (Specify)
Injury at 28d. Describe how injury occurred

Hospital:

5 Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V.R. Felipa, M.D., 925 Bishop Walsh Drive, Cumberland, Maryland 21502

32. Registrar's Signeture

Souls!

MY CENT	September 30, 2000			٧٠,	Orade Dar
Y	AllegellA	Hospira		NV. M. ONL	JOOLS DOIST LO
nt up dv ker	W 65 May 35		Čó		234-52-6113
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	Inflator	ekeeping supervisor	Noti	0	12
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21532-	story Maryland	Cest tare 11.W. Fin	1001	nby ydu	Hord "Kiffy" DC
bastand	A-Oct-00 Frostburg V	inor tonome	M produced		

Furst Funeral Home, 57 Frost Ave., Frostburg, MD, 215-72

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Dev Month **Physician** Howard Durst William Sept 16 2000 /Medical 10:30AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12007 Bedford Road Cumberland Allegany If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2□ F Months 90 Yrs 182-01-6391 April 19,1910 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 No Director Allegany Cumberland 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12007 Bedford RD. NE 21502 Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status No 4/1943 If Yes, Give Year or Dates: 11/1945 1 Never Married 2 Married 1□ Yes 2□No Specify: Specify: White p 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) production line Tire industry 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Durst Sadie Mae (Brotemarkle) Durst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virlen Stevens / 143 S. Water St., Frostburg, MD 21532 sister 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Memorial Park 9/19/2000 Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Merritt-Adams Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) sudden a Self inflicted gun shot wound to the chest Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 2 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examinar? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 9/15/00 ard 9:00 MM 2 ☐ Accident 3 ☐ Suicide subject shot himself
28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

The law requires that the deeth certificate be executed P.O. Box 68760, should be det Records, page 2 Division of Vital or Attending Physicien:

this Atter after death.

Funeral

Director

r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at

pemit. Pages 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other treumatic event, the Medical Estimation 2008.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

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Hospital 24 hours a Funeral D within 24 hor To the Fune completely fi 726

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Registrar

State

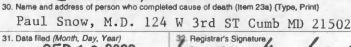
31. Data filed (Month, Day, Year) SEP 1 B 2000

4 Homicide

(Check only one)

29b. Signeture and title of certifi-

29a. Certifier



residence

Dpty Medical Ex D09157

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29c. License number

12007 Bedford Rd Cumb Md

Sept 16 2000

29d. Date signed (Month, Day, Year)

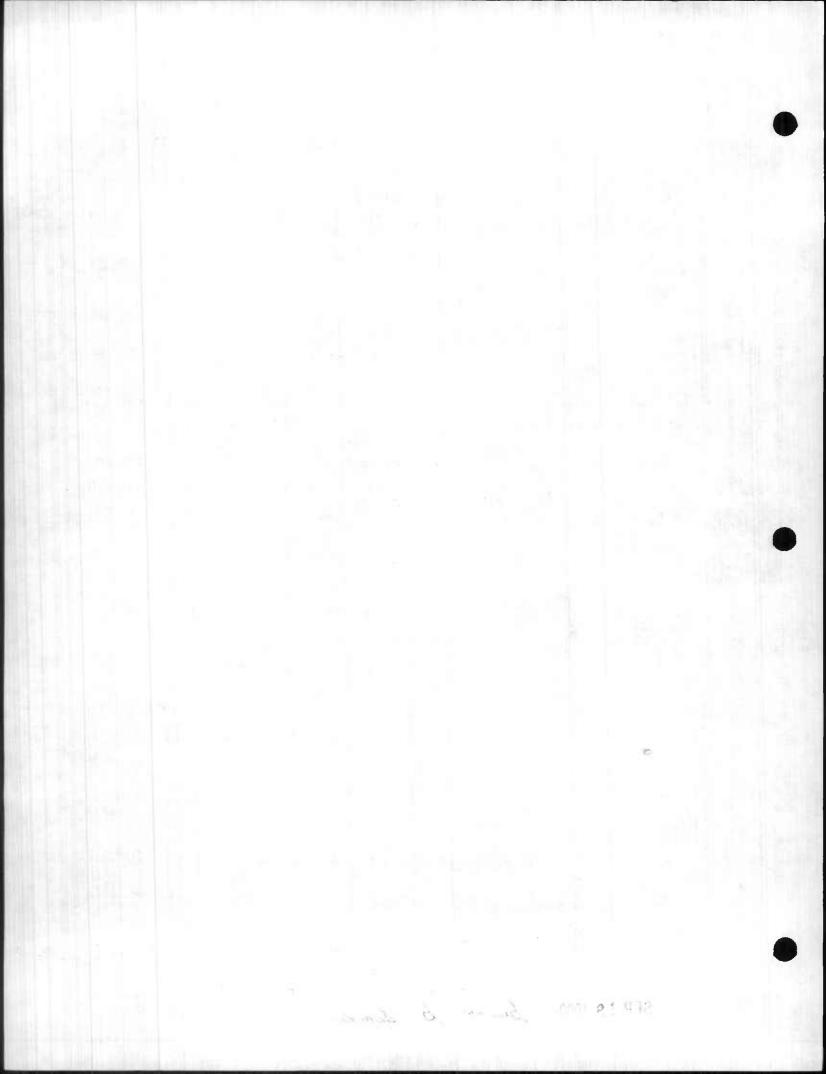
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State of Maryland / Department of Health and Mental Hygiene

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				(Certificate of	Death		Reg. No.	U ,	32430
		1. Decedent's Neme (First, Midd	le, Last)				2. Dete of De	alh		3. Time of Death
	Physician	HOWALU W EII	glish				Month Sept	. 26, 20	Yeer	11:06 pm
	/Medical Examiner	An English Stome // not institution	n, give street end number)			4b. City, Town, or L		1		ттоо ры
	Lxdillilei	31 Richardson	a Way			LaVale		A11 -		
-	Funeral	5. Social Security Number		yrs. last birtho	(ay) If Under 1 Yea		8. Date of Birt	Alle	3 Birtho	eleca (Stete or Foreign
	Funeral Director	164-26-4852 Usuel Residence of Decedent	1□ X M 2□ F 68		Months Days	Hours Min.	8. Date of Bird (Month, De June 20	y, Year) 0, 1932	Coun	pleca (Stete or Foreign htry) PA
	and w	10a. Stele 10b. County	10c	. City, Town o	or Location				1	Od. Inside City Limits
	death with the Maryland ms 23a or 28a-f show must be notified	1 MD								1XYes 2□No
	vith the Mar or 28a-fs be notified	MD Alle	gany	LaVale	10f. Zip Code			10a Citizan of h	Affron Court	100
	vith No.	Toe. Street and Number						10g. Citizen of V	Vilet Court	nry ?
	ath age	31 Richard Wa			215			USA		
	r hems 23s	11. Meritel Stetus	12. Wes Decedent Ever i Armed Forces?	n U,S.	Wes Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ben, Mexican, Puerto	ecity Yes or No Rican, etc.)	- 14. Hac	e - Americ ck, While,	
20	iges 1 and 2 should be filed within 72 hours after death with the Mandan to fileath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic avant, the Medical Exactins must be notified at or other Traumatic avant, the Medical Exactins must be notified at the Completed by Funeral Director		If Yes, Give		1□Yes 2□No	Specify:		Specify	. TT	
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Maryland	2 short and le ma	19e. Informent's Neme/Reletions	ship (Type, Print)	19b. N	Mailing Address (Stree	et and Number or Rui	ral Route Numbe	er, City or Town,	Stete, Zip	Code)
	and ealth n 27	Margaret Bevan			Richard W	ay; LaVal		21502		
Ore	of H	20e. Method of Disposition 1 Ruriel 2 Cremetion			isposition (Neme of cremetory or other pl	ece)	Dale	20c. Location -	City or To	wn, State
Ē	Pages nent of I ant: If its	4 Donelion 5 Other (S		Mellin	ger Mennon	ite Cem 9	/30/200) Lanc	aste	r, PA
Baltimore,	pemit. Pages 1 and 2 Department of Health s Important: If flam 27 is any Injury or other tra once.	21. Signeture of Funerel Service		1	22. Name end Add	ress of Fecility				
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		23a. Part1. Enter the diseese, or	r complications that caused the conly one cause on each line.	eeth. Do noi	Cumberlan	ing, such es cardiac	or respiretory e	rrest.	1	Approximate
	Dhyalalan	shock, or heert feilure. List	only one cause on each line.						1	Interval Between Onset end Deelh
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	ficate be executed physician and is the burial-transit		b							
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o	law requires that the death certificate be assecuted as been signed by the attending physician and a 2 should be detached for use as the burial-transit phieted by Physician/Medical Exami	Pert II. Other significant condition	ons contributing to death but not	resulting In th	ne underlying cause g	iven in Pert I.	23b. Did	tobacco use co	atribute to	the causa of death?
٣.	d by letac						10	Yes 2 No	3 Prof	bably 4 Unknown
Ś	bed by									
Records,	The law require pate has been single 2 should Completed						24a. Wes perfo	en eutopsy rmed?	24b. We	ere eutopsy findings eileble prior to
ပ္ပ	has be 2 sh								of	mpletion of cause deeth?
	te he page						10	res 20No	15	□Yes 2□ No
<u>a</u>	ysicien: The la is certificate ha director, page fo Be Com	25. Was case referred to medica				26. Place of Deal	th (Check only o	one)		
>	Physician: this certific ral director,	1 Yes 2 THO	Hospitel: 1 Inpalient	2 ER/Outp	atient 3 DOA	ther		dence 6 □Oth	er (Specif	(v)
Division of Vital	2 2 2		28a. Dete of Injury		e of 28c. Inju			now injury occur		,,
6	or Attending Pater death. Director: Atter I in by the funer ertification:	1 (Natural 5 Pendir 2 Accident investi		r) Inju		ork? ☐Yes 2☐No				
18	Attend or death octor: by the	3 Suicide 6 Could	nined 288. Piece of Injury - A	At home, ferm	, streel, fectory, office		28f. Location (Street and Numb	er or Rura	al Route Number,
á	tal or Attanding P rs after death. al Director: After t led in by the funera Certification:	4 Homicide	building, etc. (Sp	ecity)			City or To	vn, Stere)		
	Ports Pers		ng Physician: To the best of my	knowledge. d	leath occurred at the	time, date end place	and due to the	cause(s) and me	enner es s	itated.
	n 24 house he Fune pletely fil edical	(Check only 2 Medical one)	Examiner: On the basis of examend menner steted.	ninelion and/o	or investigetion, in my	opinion, deeth occur	red et the time,	date end plece,	and due to	the ceuse(s)
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Medical Cert	29b. Signeture and title of martine	1.1		29c. Licer	nse number		29d. Dale signe	d (Month,	Dey, Year)
		92	1/200001	m						
	15	1	vagore!	111		2181		Jep1	4	7,2000
	mes	30. Neme end eddress of person	//					0		
	1000	Gary Wagoner,	M.D. Bishop Wa		rive Cumb	erland MD	21502			
	State	31. Date filed (Month, Day, Year) SEP 2 9 201	32. Registrer's Si	gneture	1					
	Registrar				Ann Val	,				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month **Physician** 6.20Am /Medical 4c. County of Death 4b. City, Town, or Location of Deeth Facility Name (If pot institution, give street end number) Examiner If Under 24 Hrs. 8. Date of Birth Hours Min. Ja Month 4ey, Year 1921 Ltimore nor If Under 1 Yaar Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign County) **Funeral** Days 1 M X F 79 217-10-6898 Yrs Director Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits il Hygiene, other then "natural", or items 23s or 28s-f show ovent, the Medical Examinar must be notified at 1 X Yas 2 □ No Baltimore Towson Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21286 1510 Providence Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Nevar Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 3 ☐ No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Sumeme)
Aletha B (Mowbray) 17. Father's Nama (First, Middle, Last) should be nd Mental Isaac F. Knick is marked 19a. Informent's Name/Relationship (Type, Print) Ronald H. Athey 19b Mailing Address (Street and Number of Rural Route Number, City of Jawn, State Zip Gode) important: If health a important: If hers 27 is any injury or other traus once. Pages 1 and 2 s mant of Health an Saltimore, 20e. Method of Disposition

AB Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 9/27/ Sunset Memorial Park 2000 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) Scarpeddio Huneral Home, 21. Signeture of Funeral Service Licensee Cumberland, MD 21502 23a. Part1/Enter the disease, or complications that caused he death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** Immediate Cause (Final disaase or condition resulting in death) /Medical Examiner Due to (or es e consequence of): Physician/Medical Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be execut has been signed by the attending physician and e. 2 should be deteched for use as the bunal-tran Due to (or es a consequence of): Box 68760, Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Enknown þ en abstuut u Least St. year 29a. Was en eutopsy 24b. Were autopsy findings available prior to completion of causa of death? Completed 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Donth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 41 Nursing Homa 5 Residence 6 Other (Specify) 20 NO 1 Yes Certification: To

Division of Vital Records. aptal or Attending Physician: The hours after death.

reral Director: After this certificate y filled in by the funeral director, pa To the Hospital
within 24 hours a
To the Funeral C
completely filled

Medical

State Registrar

29b. Signature and title of certifier-

5 Pending investigation

6 Could not be determined

an. Coss

27. Manner of Death

1 Natural

2 Accident

3 Suicida

29a Certifier

4 Homicide

H857

29c. License number

Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

28d. Describe how injury occurred

30. Nama and address of person who completed cause of daath (Item 23a) (Type, Print)

32. Ragistrar's Signature

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

SEP 2 9 3400 / 2 ---

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 32438 Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month -Year **Physician** E. FRANK JAMES 1625 H 2000 30 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CHARLOTTE HALL ST MARY'S CHARLOTTE HALL VETERANS' HOME 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (State or Foreign Country) **Funeral** Days Months 1Q-M 2□ F 85 Yrs. 577-07-3495 Director March 29 1915 Washington, DC Usual Residence of Decedent the Meryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f ehow 1 Yas 2 No Charlotte Hall Director Maryland | St Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29449 Charlotte Hall Road 20662 USA death Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: ₩₩ II 14. Race - Amarican Indian, Black, Whita, atc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 72 hours after 1 ☐ Never Married 2 🕅 Married White 21215-0020 1 Yas 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed . 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry parmit. Peges 1 and 2 should be filled within 721 Department of Heelin and Mentel Hyglene. Important: If item 27 is marked other than "natuany injury or other traumatic event, the Medical ADDs. Public Transportation Elementary/Secondary (0-12) College (1-4or 5+) Cab Driver 8 Baitimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surneme) Be Myrtle Miller Frank Jacob H. Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26926 Tin Top School Rd Mechanicsville, MD 20659 Judith A. Herndon (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XXX Burial 2 Cremation 3 Removel from State Trinity Memorial Gardens 10-4-00 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signeture of Fat ral Survice Licensee Eberwein Funeral Services M00173 4433 White Pls La White Pls., MD 20695 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feiture. List only one cause on each line. Intarval Batween Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical DNEUMONIA Examiner Due to (or as a consequence ot): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CHRENK OBSTRUCTIVE PULMONARY DISTASE Records, by 24b. Wara autopsy findings available prior to complation of cause of death? DIABETES MELLIUS, ATRIAL FIBRICIATION, 24a. Wes en autopsy performed? DEMENTIA DEPRESSION, CORONARY ARTERY DISEASE 1□ Yas 2□ No 1 Tyas 2 No of Vital 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 28c. Injury at Work? Certification: 5 Pending investigation Division 1 Natural 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1th Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steled.

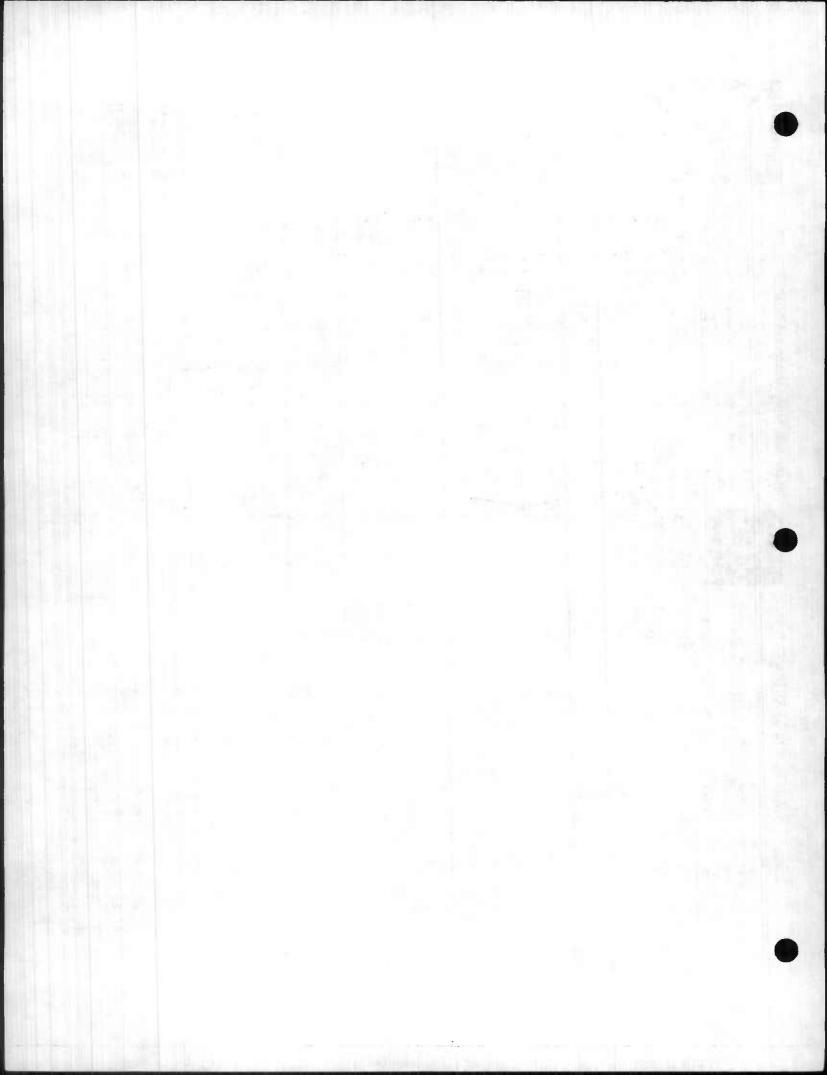
2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner steled. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) CHARCOTTE HALL RO. CHARCOTTEHAU, MD 20622 CHVH 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

OCT 04 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Physician Medical Examiner Clearview Nursing Home Funeral Director 1. Decedent's Name (First, Middle, Last) Sara Elizabeth Guild 4a Fecility Neme (If not institution, give street end number) Clearview Nursing Home 6. Sex 1 Medical 4a Fecility Neme (If not institution, give street end number) Clearview Nursing Home 7. Age (In yrs. lest birthda, 1 Medical	Hag Hag House 1 Year If Under 1 Year Hours Hours Location	2. Date of De Month Septe Town, or Location of Deet erstown	mber 29 h 4c. County Was	hington
Sara Elizabeth Guild 4a Fecility Neme (If not institution, give street end number) Clearview Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthda 1 M 2X F 87 Yrs. Usual Residence of Decedent	Hag Wonths Days Hours Location COWN	Septe Town, or Location of Deet erstown	mber 29 h 4c. County Was	9 2000 3:45AN of Death hington
Examiner 4a Fecility Neme (If not institution, give street end number) Clearview Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthda, 1 M 2X) F 87 Yrs. Usual Residence of Decedent	Hag Wonths Days Hours Location COWN	erstown	Was	hington
Funeral Director 5. Social Security Number 212-07-8264 6. Sex 1 M 2X F 87 Yrs.	If Under 1 Year	erstown ar24 Hrs. 8. Date of Bi Min. October	Was ay, _{Year)} 27,1912	hington 9. Birthplace (State or Foreign Country)
Director 212-07-8264 1 M 2X F 87 Yrs.	Location	Min. 9. Date of Bi (Month, Di October	27,1912	Birthplace (State or Foreign Country)
10a. State 10b. County 10c. City, Town or	town			Maryland
				10d. Inside City Limits
Maryland Washington Hagerst 10e. Street and Number 9946 Downsville Pike 11. Maritel Status 12. Was Decedent Ever In U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Yes 3 No 1 Yes 3 Yes 3 No 1 Yes 3 Yes	10f Zin Code			1 ☐ Yes 2 🗖 No
Maryland Washington Hagerst			10g. Citizen of W	
9946 Downsville Pike	21740		U.S.	
11. Maritel Status 12. Was Decedent Ever In U,S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	 Was Decedent of Hispanic O If Yes, specify Cuban, Mexica 	an, Puerto Rican, etc.)	Blac	a - American Indian, k, White, etc.
1 Never Married 2 Married 1 Pes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify	y:	Specify	White
10a. State 10b. County 10c. City, Town or Maryland Washington Hagerst 10c. Street and Number 9946 Downsville Pike 11. Maritel Status 12. Was Decedent Ever In U.S. Armed Forces? 1 Never Married 2 Married Maryland Maryland Maryland Maryland Mashington Maryland Maryland Mashington Magerst 10c. City, Town or Maryland Mashington Hagerst 10c. City, Town or Maryland Mashington Hagerst 10c. City, Town or Maryland Mashington Hagerst 2 Maryland Mashington Magerst 2 Maryland Mashington cedent's Usual Occupation	net of working	16b. Kind of Bu	siness/industry	
Ida	ve kind of work done during mo b. DO NOT use retired)		0.1:	
Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last)	er and Opera	TOT her's Name <i>(First, Middle</i>	1	atessen
		argaret	Estel	
David Earl Neikirk 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Num.			
0.000	7 Nelson Avenu	e. Manhatta	n Beach.	CA. 90266
20a. Method of Disposition 20b. Place of Discernetery, competery, competery, competery, competery, competery, competery, competers,	sposition (Name of rematory or other place)	Date		City or Town, State
1 N Burial 2 □ Cremation 3 □ Removal Irom State 4 □ Donetion 5 □ Other (Specify) Rest Ha	aven Cemeter	y 10-02-200	0 Hagers	town, Maryland
David L. Marsee 172 20a. Method of Disposition 20b. Place of Discernetery, or All Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licensee	22. Name and Address of Fact Andrew K. Coff	iliy fman Funeral	L Home.	Inc.
, total standing	40 East Antiet	tam Street.	Hagersto	own, Md. 21740
23a. Part1. Enter the disease, or complications that caused the deeth. Do not e shock, or heart failure. List only one cause or each line.	enter the mode of dying, such e	es cardiac or respiratory a	arrest,	Approximate Interval Between
Physician /Medical Immediate Cause (Final Acute Bronchi	al Dagumania			Onset end Deeth
Examiner disease or condition resulting in death)		d		3 days
Due to (or as a cons				(months
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that initiated events resulting in deeth) Last Due to (or ese consider the conditions) of the conditions contributing to death but not resulting in the conditions conditions contributing to death but not resulting in the conditions conditions cond				
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2 2 0 Q.	**			completion of cause of death?
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25. Was case referred to medical examiner?		ce of Deeth (Check only	one)	
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Hospital: Inpatient 2 ER/Outpet 27. Manner of Death 28e. Dete of Injury 28b. Time		Nursing Home 5 Res	idenca 6 Othe	
27. Manner of Death 1/2 Natural 5 Pending (Month, Dey Year) 1/2 Natural investigation			now injury occur	60
2 Accident investigation 3 Suicide 6 Could not be determined determined		28i. Location	(Street and Numb	er or Rural Route Number,
27. Manner of Death 12 Natural 28. Dete of Injury 28. Dete of I		City or 16	iwn, State)	
25. Was case referred to medical examiner? O				
29b. Signature and title of certifier	29c. License number	r	29d. Date signed	d (Month, Day, Year)
Three Mark the	D07857	A STATE OF THE STA	Septem	ber 29, 2000
30. Name and address of person who completed cause of death (Item 23a) (Typ	pe, Print)			

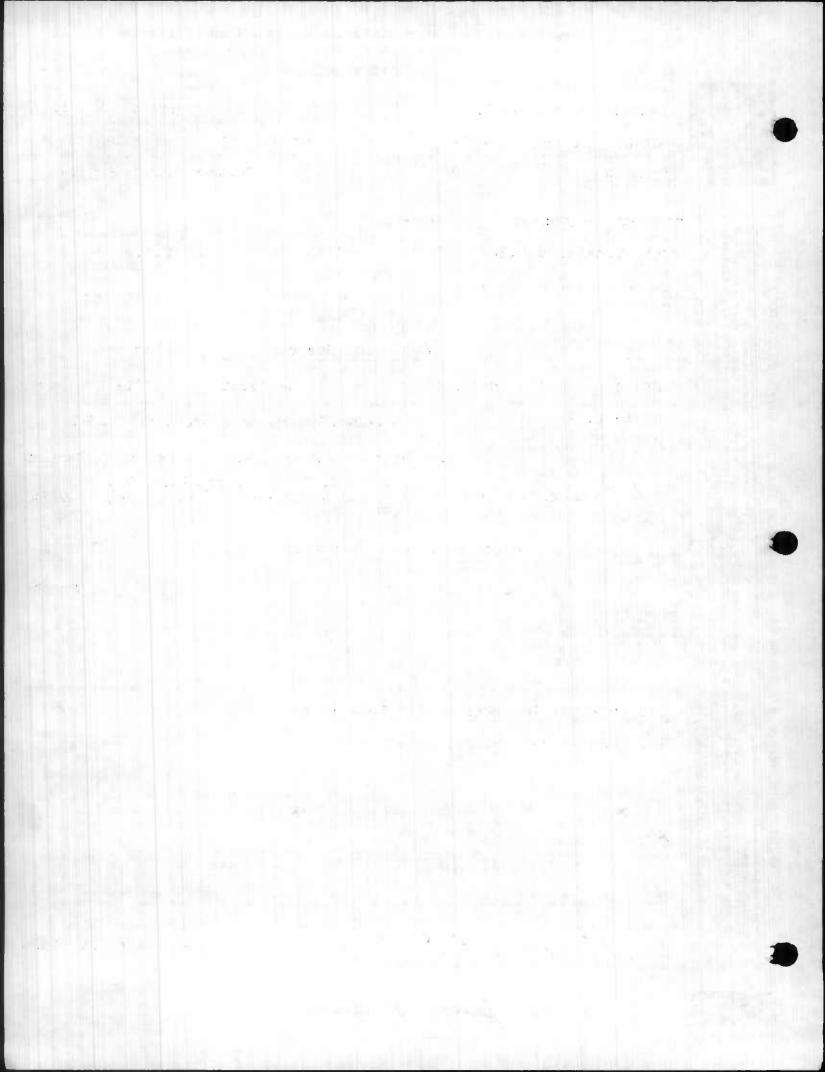
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31. Date filed (Month, Day, Year)

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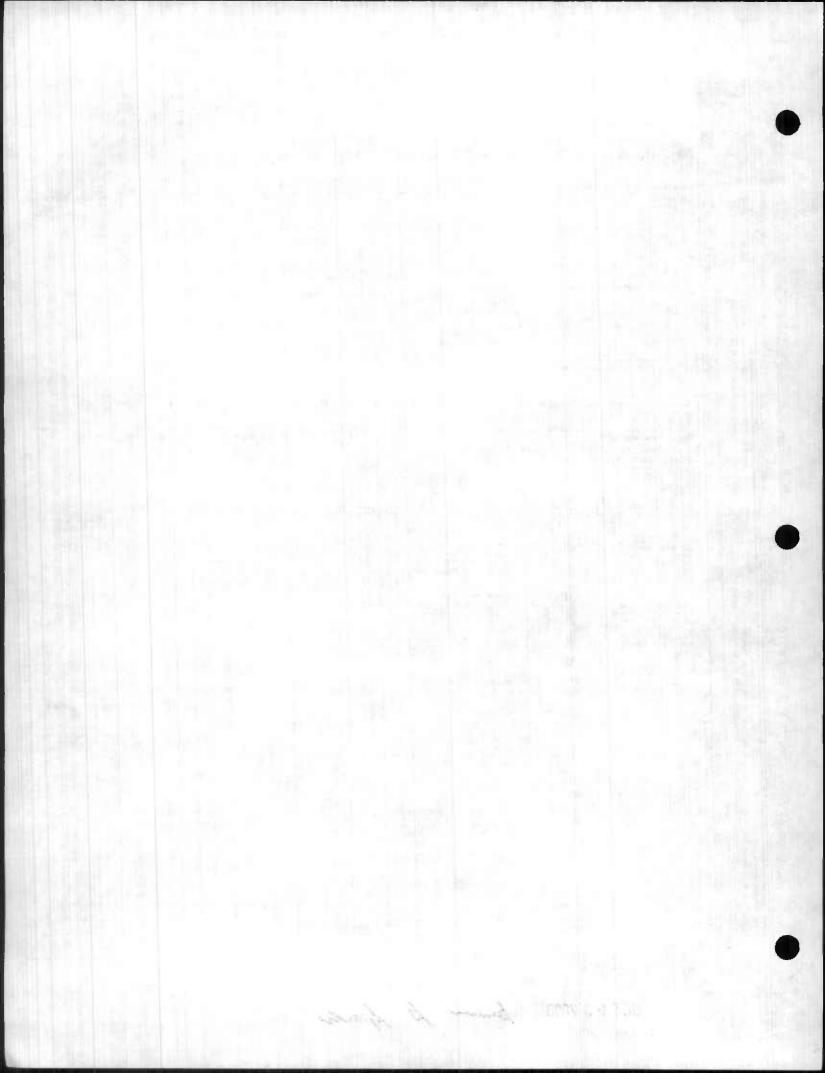
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	/Medical		ROSS			Ab City Town	September or Location of Deep		2000 4:10 P.M.
4	Examiner	4a Facility Name (If not institution, giv 408 North Mecha	Carlotte Annual Control		4.5			,	
_	Funeral	5. Social Security Number 6. S			If Under 1 Year		rs. 8. Dete of B		9. Birthplece (Stete or Foreign Country)
	Director	217-10-7464	№ 2□F 82	Yrs.	Months Days	Hours M	JAN . 6		VIARYLAND
	2 .	Usual Residence of Decedent	100 00	Town and and					
	athon show	10a. State 10b. County		ty, Town or Loca					10d. Inside City Limits 11 Yes 2 □ No
	the Man refiled rector	MARYLAND ALLEGA 10e. Street and Number	NY	CUMBERL	AND 10f. Zip Code			10g. Citizen of V	21
	23e or 23e or 31 Dir	408 NORTH MECHANI	C STREET		215	.02		U.S.A	
	me 2 rms 2	11. Meritai Status	12. Was Decedent Ever in U	,S. 13. Wa			(Specify Yes or Nuerto Rican, etc.)		e - American Indian,
0	or he mine	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		Yes 212 No		erro Hican, etc.)		ck, White, etc.
902	Eral.		Year or Dates:		TE 166 ZE 160 Specify.				WHITE
5	"natur edical	15. Decedent's Ed (Specify only highest gra		(Give kir	nt's Usual Occu nd of work done NOT use retire	during most of	working	16b. Kind of Bu	usiness/Industry
175	rigions. Projects. At the Media	Elementery/Secondery (0-12)	College (1-4or 5+)				BROTHER	DI IIMR	ING/HEATING
P	tal Hyginal digital di			OWNER	OI LIKATO	_	Name (First, Middle		
lan	Asmita Asmita Ilic ev					LEO	TA HIMML	ER	
Maryland 21215-0020	and A	t9a. Informant's Name/Relationship (Rural Route Num		
	and saith n 27	ROBERT A. GROSS	BROTHER	1		HANIC S			MARYLAND 21502
Ore	Pages I heart of H ant: If Ne ary or oth	20a. Method of Disposition 1	Removal from State	Plece of Dispositi cemetery, creme	tory or other ple		Dete		City or Town, State
Baltimore,	franch duny	4 Donation 5 Other (Specif	<i>'</i>				R 3 2000	CUMBERL	AND MARYLAND
Bal	Dapa Impo any ir	21. Signeture of Funeral Service Licer	1500		Name and Addr RRITT-A		NERAL HON	ME P.A.	
		23a. Part1. Enter the disease, or com	MUS specifical that deat				ET CUMBER		RYLAND
Ca.	Physician	shock, or heart failure. List only	one cause on each line.	III. DO NOT STASI	the mode of dy	ing, such as care	alec or respiratory	arrost,	Interval Between Onset and Death
	/Medical	Immediate Cause (Final	ATHEROSCLEROTI	C CARDIOV	ASCIT AR I	TSEASE			
	Examiner	disease or condition resulting in death)	8	or es e conseque		JIBENDE			1
-	D z G			1					
	be executed sician and bunal-transit	Sequentially list conditions,	Due to (c	or es e conseque	nce of):			tu ion	
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87	the the	resulting in deeth) Last	Due to (o	er as e conseque	nce of):				
9 x c	leath certifical attending place as the for use as the form of the		d						
Box	at the death certific d by the attending p letached for use as Physician/Mex	Part fl. Other significant conditions of	contributing to death but not res	ulting in the und	edvina cause a	iven in Part I	23h Df	t tobacco use co	ntribute to the cause of death?
P.0	by the tached	Tarris, Otror argumount conditions	onthibuting to doubt hot hot res	outing in the one	onying oadso g			Yes 2□No	3 Probably 4 ₩ Unknow
Ś	by bed by						-		
Record	The law requires ale has been sign page 2 should be Completed by							s an autopsy formed?	24b. Were autopsy findings aveilable prior to completion of cause
ec	has by pe 2 st	•		-					of death?
	cate has cate has Com						D2	Lyes 2□No	yes 2□ No
Vitai	Physician: The this certificate ral director, page TO Be Co		Hospital:		0	4	Death (Check only		
of	hys his	A	1 Inpatient 2	28b. Time of	3LI DUA	4 LI NUISIN	g Home 5 Re	how injury occur	000000
on	ding th. After fune	1 XNatural 5 Pending Investigation	(Month, Dey Year)	Injury	28c. Inju Wo	ork?]Yes 2 □ No			
Division	f or Attendi after death. Director: A d in by the fi	3 Suicide 6 Could not be determined	289. Piece of injury - At n		t, fectory, office).	28f. Location	(Street end Numi	ber or Rurel Route Number,
ā	is after death. If Director: After ted in by the funers Certification:	4 Notificide	building, etc. (Specif	197)			Only or 1	own, bioloy	
	he Hospital in 24 hours in the Funeral pletely filled edical Ce	29a. Certifier 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina						
	the H the F the F nplete		and manner stated.			ise number			d (Month, Day, Year)
	or or or or or or or or or or or or or o	29b. Signeture end title of certifier	001			C.M.E.			er 28, 2000
		Mennis	J. Chutzni	7 23a) (Turas Ca					
		30. Name and address of person who	, pioted oadde of death (liter	11 20a) (1 ypo, P1					

State Registrar 31. Date filed (Month, Dey, Year)
OCT 0 3 2000

Chutero 32. Registrer's Signeture

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month Year 10:25 PM SEPTEMBER 26 2000 GERALDINE ALVERTA HOEY GILBERT 4a Facility Nama (If not institution, giva streat and number) 4b. City. Town, or Location of Death 4c. County of Death CUMBERLAND 611 COLUMBIA AVENUE ALLEGANY If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) Days Months 10 M 20 F 75 Yrs. 219-14-7173 IUNE 22 1925 MARYLAND Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. fnside City Limits NXYes 2 □ No MARYLAND ALLEGANY CUMBERLAND 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 611 COLUMBIA AVENUE 21502 U.S.A. 14. Race - American Indian, Black, Whita, etc. 11. Marital Status 12. Was Decedant Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-ff Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1 Nevar Married 2 Married 1 ☐ Yas 2 No If Yes, Giva Yaar or Datas: 1 ☐ Yas 2X No Specify: WHITE Specify 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PARA-LEGAL/DENTIAL TECHNICIAN PARA-LEGAL 12

18. Mothar's Nama (First, Middle, Maiden Sumame)

LULA MAUDE BLACKBURN

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)

permit. Pages 1 and 2 should be file Department of Haalth and Mental Hy Important: If them 27 Is marked other any finjury or other traumatic avent other. **Physician** /Medical

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f ahow

natural, or

the Medical Examiner must be notified at

TO

Funeral

Completed

Be

17. Father's Neme (First, Middle, Last)

19a. Informant's Name/Ralationship (Type, Print)

AUSTIN A. HOEY

with the Maryland

death v

hours after

filed within 72 Hygiene.

altimore. Maryland 21215-0020

Examiner

certificata be executed and physician ar attending | signed by the Records, page 2 s certificata Division of Vital al or Attanding Physician: T s after death. If Director: After this certificat ed in by the funeral director, p To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Box 68760

P.O. |

Examiner Physician/Medicai þ Completed Be Certification: To

DAUGHTER RFD#2 BOX613A SHORT GAP, W.VA. 26753 ANITA SALESKY 20b. Plece of Disposition (Nama of cematary, crematory or other plece) 20e. Mathod of Disposition Data 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Removal from Stata SUNSET CEMETERY SEPTEMBER 30 2000 CUMBERLAND MARYLAND 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensaa 22. Nama end Addrass of Facility MERRITT-ADAMS FUNERAL HOME P.A. 0(. erull 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Part1. Enfer the disaesa, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on sech line. Anten Disense Immediata Causa (Final Coronary disaesa or condition rasulting in daath) o bstructic Sequentially list conditions, if any, leeding to immadiata cause. Enter Undarlying Cause (Disease or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part f. 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No 25. Wes casa referred to madical examiner? R.E.L.E.A.S.E.D. 1\(\tilde{\D}\) Yas 2\(\tilde{\D}\) No 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home MXResidence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Deeth 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending invastigation 1 Netural 1 Yas 2 No 2 Accident 3 Suicida 6 Could not be datarmined Location (Street and Number or Rural Route Number, City or Town, Steta) 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide McCortifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and mennar as stated.

2 Medical Example: On the basis of dramination and/or invastigation, in my opinion, deeth occurred at the tima, data and placa, and due to the cause(s) and manner stated. edicai 29a. Cartifiar (Check only one) 29b. Signatura and fitta of certifie 29c. Licanse number

29d, Data signed (Month, Dav. Year) D 36766

LAVALE, MARYLAND

SEPTEMBER 27, 2000

21502

Approximate Intarval Between Onset and Death

Sept 27, 2000

3 Probably 4 Unknown

24b. Wera autopsy findings available prior to

completion of cause of death?

1 ☐ Yes 2 ☐ No

contribute to the cause of death?

e4.75

MA State Registrar

10

DR VIK POONAI 31. Data filed (Month, Day, Year) SEP 2 9 2000

32. Registrar's Signatura

920 NATIONAL HIGHWAY

30. Name and address of person who complated causa of daath (Item 23a) (Type, Print)

souls

9 mil 6 4 6 13

State of Maryland / Department of Health and Mental Hygiene 10 221.1.2

					Certificate of	of Death		Reg. No.	0 0	2446		
	Ohuminian	1. Decedeni's Name (First, Middle, Last)		J. P. R. L.		2. Dale of De Month	ath Dey	Year	3. Tima ol Death		
	Physician /Medical	Lawrence	Randolp	oh Gil	len			BER 22,		9:20 PM		
	Examiner	4a Facility Nama (If not institution, give	street and number)			4b. City, Town, or	Location of Death	ath 4c. County of Death				
		VA MARYLAND HEALTH	CARE SYS	STEM		PERRY P	OINT	CEC	CIL			
	Funeral	Social Security Number 6. Se		ge (In yrs. last birt	Months Da			h v. Year)	9. Birthple	ace (Stete or Foreign		
	Director	214-07-0334	XM 2□ F	85	rs.	,	July 18			inia		
	2 .	Usual Residence of Decedent 10a. Stata 10b. County		10c. City, Town	or Location				140	od tasida Ois I i-is-		
5	anyla anyla		+	Toc. City, Town					10	od. Inside City Limits 1 ☐ Yas YeV No		
3	or 28s-f s be notified	Maryland Dorches	ter		Cambridge							
Ó		10e. Street and Number			10f. Zip Cod	e		10g. Citizen of What Country				
R	her death v r herrs 23a siner must Funeral	6033 Corners Whar		-		1613			JS			
	Per de	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decedent	of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yas or No rto Rican, etc.)	- 14. Had	ce - America ck, Whita, a			
20	M. or all	1 ☐ Never Married 2 ☐ Married \$\infty \infty \ino	XXYes 2□ If Yes, Giva	WW II	1 ☐ Yas 3 💢	No Specify:		Specif	y: Wh	ite		
215-0020			Taar Of Datas.					46h Kind -4B				
15	led within 72 ho tygiene. her than "naturn it, the Medical.] Completed	15. Decedent's Edu (Specify only highest grad	de completed) (Give kind of work			ne during most of w	orking	16b. Kind of B	usiness/indi	ustry		
272	the Man	Elementery/Secondary (0-12)	College (1-4or	5+)	Accountant			Food I)wo ao a	aina		
	Had Had	17. Father's Name (First, Middle, Last)			Accountant		ama (First, Middle,	Food F		sing		
girr	Mental H Mental H arked off affic ever To Be	Oliver Putnam				Edna	Mae Dix	2				
5	T T	19a. Informant's Name/Ratationship (T)	rpe. Print)	19b.	Meiting Addrass (Str				State Zio	Code)		
Z E	and 2 is saith ar n 27 is ar trau	Charlotte A. Lewi										
ore,	一工具有	Charlotte A. Lewis Daughter 6033 Corners Wharf Road Cambridge, Mary 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Cemetery, cremetory or other place)										
I'More,	appearing of the paring of the	XX Burial 2 Cremetion 3 F			ester Memor		0/26/00	Cambri	dao	Maryland		
	ortan Injur	4 Donation 5 Other (Specify) 21. Signature of Luneral Service Licens		LOTCHE				Callibri	.uge,	rat ytanu		
Bal	Depu	· // —//	/		Thomas F	drass of Facility uneral Hor	ne, P.A.					
		John John	mer	data da de Da		st Street			land			
		23a. Part / Enler tha disease, or compt should or heart laitura. List only or	ne cause on aach li	ine.	ot enter the mode of	dying, such es cardi	ac or respiratory e	rest,		Approximete Intarvat Between Onset and Death		
	Physician /Medical	Immediate Causa (Final							1	Criser and Deam		
	Examiner	diseasa or condition rasulting in death)	CORON	ARY ARTE	RY DISEASE	8			I	UNKNOWN		
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	ficete be executed physician and st the burial-transit		b						i			
_6	ificate be executed g physician and as the burial-transit ledical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or es a c	onsequence of):				1			
68760,	physician s the buria	Cause (Disease or injury that initialed events	C						1			
89	ficate physis the	rasulting in death) Last		Due to (or as a c	onsequence or):				-			
Вох			d									
m	ilen: The law requires that the death cer ntificate has been signed by the attendir ctor, page 2 should be detached for use Be Completed by Physician/A	Part II. Other significant conditions cor	atributing to death b	ut not reculting in	the underlying enurs	shop in Dad I	22h Did	lohacco usa co	mtelburte to	the cause of death?		
P.0	that the ded by the detached	Part II. Other significant conditions con	iniboting to death b	at not resulting in	tha underrying cause	given in Part I.		Yes 2 No		57		
	es that igned to be det	CORONARY ARTERY B	IPASS GRA	\FT				2010	00,,00	abiy valoritin		
Records,	requires						24a. Was	an autopsy		re eutopsy tindings		
0	w require been si should	HYPERTENSION					perio	med?	con	ilable prior to npletion of cause leath?		
æ	The law ate has b page 2 st	DESCRIPTION TO TOTAL	m presse	2			10	Yes 2 No		Yas 2□ No		
Vitai	certificate rector, page Be Co	DEGENERATIVE JOIN 25. Was casa referred to medical	IL DISEASI	2		26 Place of D	eath (Check only o			7745 2010		
>	yalclan: s certific director,	axaminer?	lospital: 1 ☐ Inpatio	ent 2 ER/Out	patient 3 DOA	Other	Homa 5 ☐ Resid		nar (Snacihi	4)		
o	Physic rithis or and direction T. To	27. Manner of Death	28a. Data of Inju (Month, Da			njury et Work?	1	how injury occur		,		
0	ding h. After fune	1 Netural 5 Pending 2 Accident investigation	(Month, Da	y Year) Ir		Nork? I∐Yes 2∐No						
Division	of Attending Physician: after death. Director: After this certific d in by the funeral director, ertification: To Be (3 Suicide 6 Could not ba	28e. Plece of Ini	jury - At homa, lai	m, street, factory, offi	Ce	28f. Location (S	Street and Numi	ber or Rural	Route Number,		
á	after Direction	4 Homicide	building, at	c. (Specify)			City or To	vn, State)				
	and Allie	29a. Certifier 1 Certifying Phys	sician: To the best	of my knowledge,	death occurred at the	e tima, data and place	e, and due to the	cause(s) and m	annar es sta	ated.		
	To the Hospital or Attending P within 24 hours after death: To the Funeral Director: After to completely filled in by the funeral Medical Certification:	(Check only 2 Medical Examination)	ner: On the basis of and manner st	f axamination and	Vor investigation, in m	ny opinion, death occ	curred at the tima,	data and place,	and dua to	tha causa(s)		
	Methin Forth Somp	29b. Signature and little of certifier			29c. Lic	ense number		29d. Data signe	ed (Month, D	Day, Year)		
		Mulus J	auto	Mi	1510	094-1		SEPTEMB	ER 22	, 2000		
		30. Nama and addrass of person who co	ompleted cause of c	leath (Item 23a) (,		
		MELECIA SANTOS, M				RE SYSTEM	PERRY F	OINT, M	D 21	902		

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State

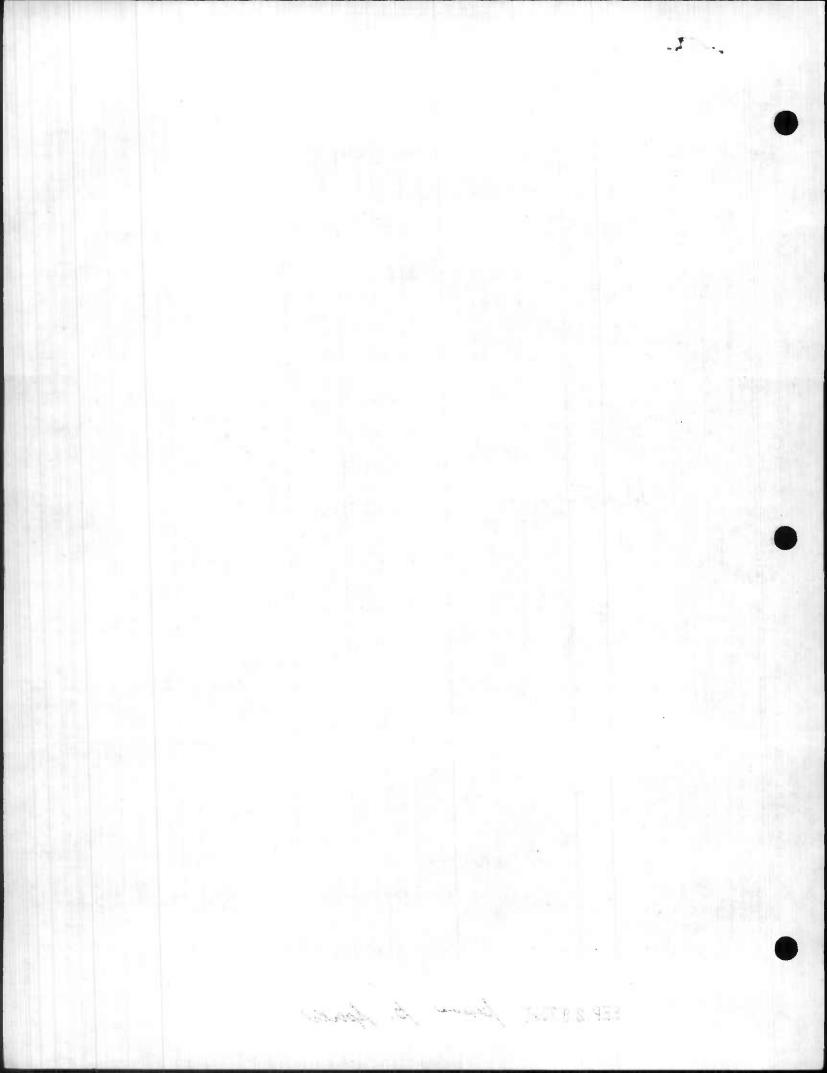
Registrar

31. Data liled (Month, Day, Year)

SEP 2 9 2000

NAME KNOWN TO PHYSICIAN:

32. Registrar's Signatura



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Deta of Daeth 3. Tima of Deeth Month **Physician** 2000 JAMES GROSS SEPT 24 1733 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (ff not institution, giva street and number) 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Undar 24 Hrs. Houra Min. If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 9. Birthplaca (Stata or Foreign **Funeral** Days XXM 2 F Yrs. 91 MARYLAND Director 1909 216-16-4596 Usual Rasidence of Decedent the Meryland 10a, Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at XXYes 2 No Director MARYLAND ANNE ARUNDEL LOTHIAN 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Funeral 5025 SOLOMONS ISLAND ROAD 20711 USA death 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. 11. Marital Status Pages 1 and 2 should be filled within 72 hours after ment of Heelth and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yas, Giva Yaar or Detas: 1 Never Married 2 Narried Maryland 21215-0020 1 ☐ Yes XIX No Specify: BLACK Specify PV 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) SELF EMPLOYED SHARE CROPPER 3rd 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Name (First, Middle, Last, Be 7 is marked of MALCOM GROSS SUSAN PINDELL 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 0.711 19a. tnformant'a Name/Ralationship (Type, Print) 5025 SOLOMONS ISLAND RD. LOTHIAN, MD. AGNES PINKNEY (DAUGHTER) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) MT. ZION CHURCH CEME. 9/29/00 LOTHIAN, MD 22. Nama end Address of Fecility M00482 WM. REESE & SONS MORTUARY, P.A. elsa Harry WEST ST. ANNAPOLIS. MD. Approximata Intarval Batween Onsat end Daath 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast shock, or heart failure. List only one cause on each line. Physician Immediata Causa (Final diseasa or condition rasulting in death) /Medical yeamoni **Examiner** Qua to (or es a consaquance of): Physician/Medical Examine Vuc 55 The lew requires that the death certificate be executed attending physicien and for use es the burial-transit Sequentially list conditiona, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated evants raaulting in death) Last Box 68760. Dua to (or as a consequence of) USB 85 t P.O. Part II. Other significant conditions contributing to death but not resulting in tha undarlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown þ of Vital Records, Be Completed 24a. Was an autopsy 24b. Wara autopsy findings available prior to completion of cause of death? certificate hes 2 No 1 Yas 1 Yas 2 No or Attending Physician: funeral director. 25. Was casa ratarred to medical axaminar? 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28c. tnjury at Work? 28b. Tima of 28d. Dascribe how injury occurred After Division 1 Natural 2 Accident 5 Pending Invastigation efter deeth. 1 Yas 2 No the 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 Homlcida To the Hospital o within 24 hours eff To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and the of partifier 29c. Licensa number 29d. Data signed (Month, Day, Year) rson who completed causa of daath (Itam 23a) (Type, Print) Medical Conter ps MD Anne les 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar

DHMH 16 Rev 6/95

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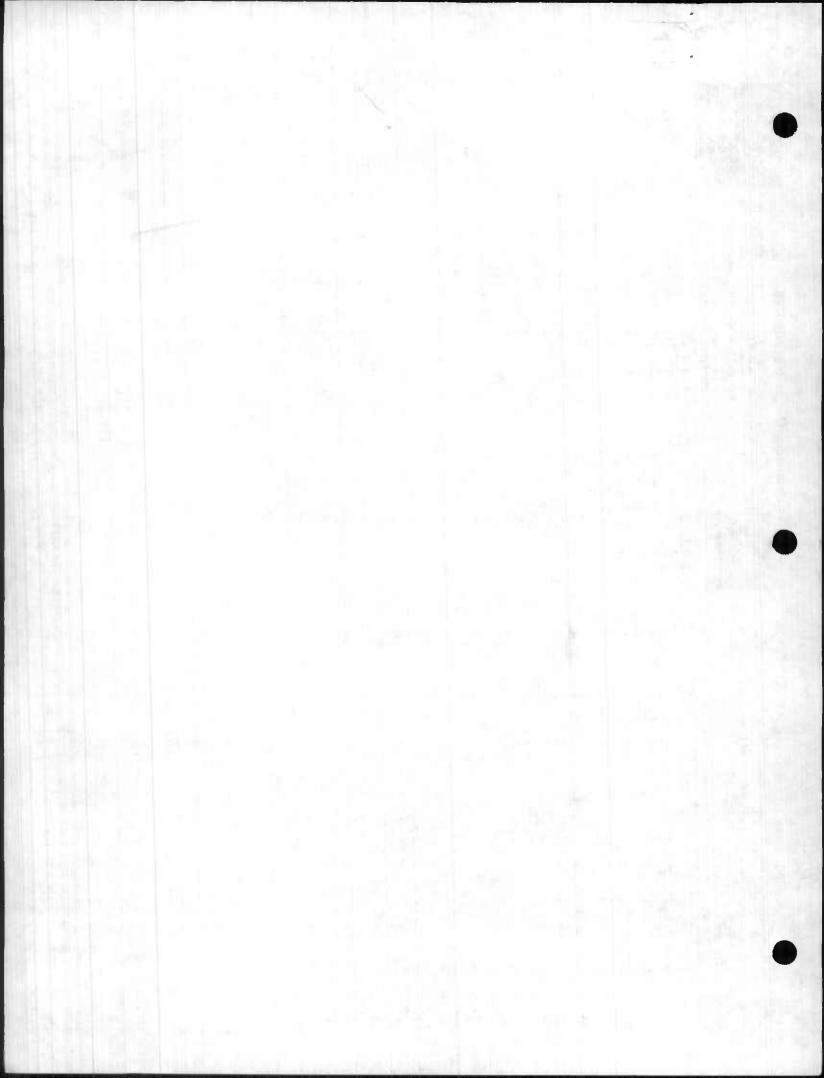
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				Otato or it	viaryiai		Certificat		Death		Reg. No.	0 (32444
	6.7	_	1. Decedent's Name (First, Middle, L.	est)						2. Date of De	ath Day	Year	3. Time of Death
	Physicia: /Medica		CHARLOTTE MAR	IE HAYN	ES					Septem		2000	1825
	Examine	-	4a Facility Name (If not institution, gi	ve street and number	er)				4b. City, Town, or L			of Death	
	·		WASHINGTON COUN						HAGERS			ASHIN	
	Funeral Director			Sex 7.7 1□M 2以F	Age (In yrs.		Months	Days	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, De MAY 8,	th y, Year) 1921		lace (State or Foreign http) RYLAND
	D Em	- 1-	10a. Stete 10b. County		10c. Cit	ty, Town	or Location					1	0d. Inside City Limits
	the Mary 28a-1 sh notified	io l	MARYLAND WASHI	NGTON					BOONSBORG)			1⊠Yes 2□No
	or 28a-f	×	10e. Street end Number	HOLOH	1		10f. Zip	Code	DOONDDOIN		10g. Citizen of V	What Coun	itry?
	A Mile	2	120 LAKIN AVENUE					21	.713		U	S.A.	
	ons dear	nec	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U	,S.	13. Was Dece		Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		e - Americ	an Indien,
21215-0020		Dy Fu	1 ☐ Never Married 2 ፟ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 22 If Yes, Give Year or Date:	No				Specify:		Specify	<i>/</i> :	WHITE
5-0	72 hz	Completed	15. Decedent's E (Specify only highest gr			16a.	Decedent's Usu (Give kind of wo	al Occup	oation during most of work d)	ing	16b. Kind of B	usiness/Inc	dustry
121	Pan Pan	E E	Elementary/Secondery (0-12)	College (1-4o	or 5+)								
			12 17. Father's Name (First, Middle, Las	1)			AC	COUN	TANT 18. Mother's Nam	a /First Middle			NUFACTURING
Maryland		0 126	DANIEL E. NICODE						ANNA I.			10)	
7	M M M M M M M M M M M M M M M M M M M	=	19a. Informant's Name/Relationship			19b.	Mailing Address	s (Street	end Number or Rui			Stete. Zip	Code)
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re,	F Hose		20a. Method of Disposition			laca of	Disposition (New	me of		Date	20c. Location -		
timore	Page ant o nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Special		te		ORO CEM			/29/00	ROONSRO	ORO	MARYLAND
Balti	A interest	1	21. Signature of Furieral Service Line		1 100	OIIDL	7		ess of Facility				
00	FREE		I will Mills	Paul	M. De	ean	BAST FU	JNER	AL HOME		d Nation		
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caus	ed the deal	h. Don	ot enter the mod	de of dyi	ng, such as cardiac	or respiretory e	rrest,	yrand	Approximate Interval Between
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16	/Medical Examiner		Immediate Cause (Final disease or condition		Con	son	hin H	ear	it fait	un			2-3 drys
	THE RESERVE		resulting in death)		Due to (or es a c	onsequence of)	:	or Faith		1000	1	
_	De ii			b	سلتا	2	Brea	4	Carci.	Long			3 700
	be executed ician and buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (d	or as a c	onsequence of):						
68760,	8 5 5	100 E	Cause (Disease or injury that initiated events	C	Due to (c	r es a c	onsequence of):						
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P.O.	d by ti	E	deterio rele	notice c	indi	ova	nalon	0	near.	10	Yee 2 No	3 Pro	bably 4☐€Unkhown
	signe bed bed	2	Diants in									0.4h 14/	and a state of the disease
0.0	been si should	Completed	Dinhs M	ellelling						24a. Wes	an eutopsy ormed?	ev	ere autopsy findings alleble prior to impletion of cause
3ec	hes b	du		A Miles	76:5								death?
a	cate h									10	Yes 2 No	1[Yes 2 No
N. N.	Physician: The lav this certificate hes ral director, page 2		25. Was case referred to medical examiner?	Hospitel:				_ Ott	26. Place of Dee				
Division of Vital Records,	Physical distribution of the state of the st	0	1 Yes 2 No	-	atient 2	28b. T		28c. Inju Wo	4 □ IAntaitid U		denca 6 Oth how Injury occur		у)
on	ding the fune	IOL	1 Neturel 5 Pending 2 Accident investigation	28a. Date of Ir (Month, I	Dey Year)		ijury M		rk?]Yes 2∐No				
/isi	Attending or deeth.		3 ☐ Suicide 6 ☐ Could not I	289. Placa of	Injury - At h	ome, far	m, street, factor	y, office		28f. Location (Street end Numi	ber or Rure	el Route Number,
Ö	afte din t	2	4 Homicide	building,	etc. (Specia	(y)				City or To	wn, State)		
	To the Hospital or Attending Phy within 24 hours after deeth. To the Funeral Director: After this completely filled in by the funeral	edical certification:		hysician: To the bes miner: On the basis end manner	of examine								
	Nithin Vithin To the	_	29b. Signature and title of certifier				29	c. Licen:	se number		29d. Date signe	d (Month,	Dey, Year)
			-	ord mo				01	8019		Safet	27,	2000
			30. Name and address of person who	completed cause o	f death (Iter	n 23a) (Type, Print)	1				147	
			Dr. Datta	334	mill	S	+. +	tag	Md	2174	0		
	State	7	31. Date filed (Month, Dey, Year)		strar's Signa	ature	4 /	ark.	1				131
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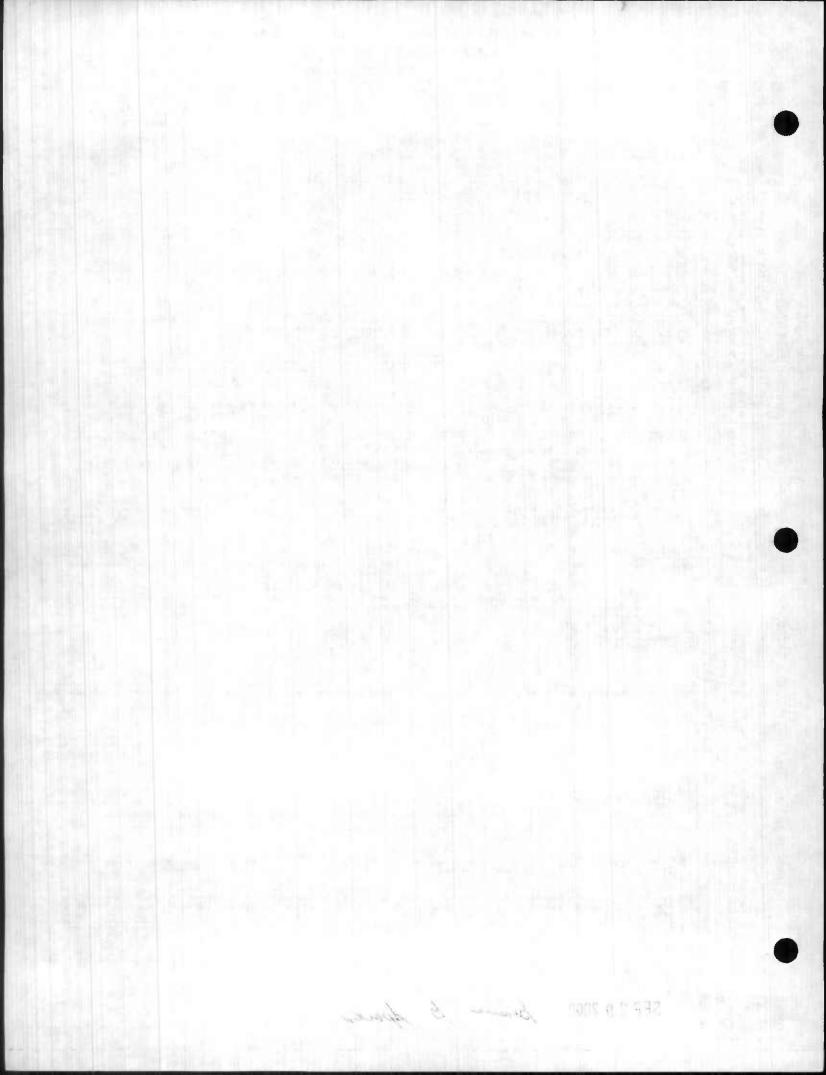
Haynes, Charlotte Marie



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			State of Maryla	Certifica				Reg. No.	0 3	2445		
	Physician	Decedent's Name (First, Middle, Las Ray A	d) .lfred	Hott		Sr.	2. Date of D Month 9	Day	Year 000	3. Time of Deeth 3:17 am		
	/Medical Examiner	4e Facility Name (If not institution, give		11000		4b. City, Town, or L				3.17 all		
	- LAUTHITET	Memorial Hos	pital & Medi	cal Center		Cumberland Allega			any			
	Funeral Director	213 20 0071	7. Age (In your Park)	Month	der 1 Yeer hs Days	If Under 24 Hrs. Hours Min.	8. Date of B May 7,	irth ley. 1923	9. Birthola Countr	ice (Stete or Foreign		
	E S III	Usual Residence of Decedent 10a. Stale 10b. County	10c.	City, Town or Location					10	d. Inside City Limits		
	Many Med at Med a	PA Bedfo	rd	Hyndma	n					1 ☐ Yes 🏋 ☐ No		
	ith with the Marys 23e or 28e-f sho ust be notified at	10e. Street and Number 1907 Cooks Mill	Road	10f.	Zip Code	15545	10g. Citizen of What Cou USA			y?		
020	urs sher des str, or items Examiner m by Funer		12. Wes Decedent Ever in Armed Forces? 1√2 Yes 2 □ No If Yes, Giver Year or Datw:W I	_ 1 □ Vas	cedent of F pecify Cub	dispento Origin? (Spen, Mexican, Puerto Specify:	en, Mexican, Puerto Rican, etc.) Blad					
215-26-6871 yland 21215-0020	ad within 72 ho ygene. wr then "natur it, the Medical. Completed	15. Decedent's Ed (Specify only highest grader)	ucation de completed) College (1-4or 5+)	1	work done Tuse retire	pation during most of work d)	king	16b. Kind of B		ustry		
	Hygie Hygie and Brand Br	12 17. Father's Name (First, Middle, Last)		Carpente	T	18. Mother's Nam	ne (First, Middle	Carpen				
215-2 aryland	Mental Me	Samuel Walker H		1		Anna L	(Wils	son)				
2	and 2 st ealth and m 27 is m her traum	19a. Informant's Name/Relationship (7 Linda McMannis		1907 Coo	ks M		a;Hync	lman PA	1554	15		
RAY HOTT Baltimore,	Pages 1 nent of H mt: If the my or off	20a MeMod of Disposition 20 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	Place of Disposition (I cemetery, cremetory of Stlawn Me	or other ple		10/02	LaVal				
RAY	Departs Departs Imports any Inju	21. Signature of Funeral Service Licens		Scar	perr	i Funer nd, MD	al Hom					
A	Physician /Medical	23a. Pent1. Enter the disease or shock, or heart failure. List	me cause on each line.	eeth. Do not enter the m	node of dyir	ng, such as cardiac	or respiratory	arrest,		Approximete Interval Between Onset and Death		
<u> </u>	Examiner j	resulting in death) Due to (or as a consequence of):										
),	cate be axecuted physician and s the burial-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	b. Due to	o (or as a consequence of	of):			AE.		p la l		
	O 0 0	resulting in death) Last	cDue to	(or es a consequenca o	of):							
Θ.	deeth e atter od for t	Part II. Other significant conditions co	ntributing to death but not r	esulting in the underlyin	g cause giv	ven in Part f.	23b. Dfc	i tobacco uae co	ntribute to	the cause of death		
P.O.	requires that the deeth certification signed by the attending hould be detached for use a hould by Physician/Meted by Physician/Meted			46 195			10	Yes 2 No	3 ☐ Probe	ably 4 Unknow		
Division of Vital Records,	The lew requires that sate has been signed to page 2 should be det.							s an autopsy formed?	avai	re autopsy findings ilable prior to apletion of cause eeth?		
Re	The lew atta hes by page 2 s						10	Yes 2 No	10	Yes 2 No		
/ita	certificate rector, pag	25. Was case referred to medical				28. Place of Dea	th (Check only	one)				
on of \	T Sign	1 Yes 2 No	Pospitel: Inpatient 2 28a. Date of Injury (Month, Dey Year)	28b. Time of	28c. fnjur Wor	4 LI Nursing H		sidence 6 Oth how injury occur	, , , ,,)		
Division	or deatler by the	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - Al building, etc. (Spe	t home, farm, street, facticity)		103 2 2 10		(Street and Numbown, State)	ber or Rural	Route Number,		
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the Medical Certifical		relation to the best of my kiner on the basis of examination anner stated.	nowledge, deeth occurrination and/or investigati	ed et the tii ion, in my c	me, date and place, opinion, deeth occur	, and due to the rred at the time	e ceuse(s) and ma , date and plece,	anner as sta	ated. the ceuse(s)		
	within To the comp	29b. Signeture and title of pertifier			29c. Licens			29d. Date signe				
•	10	30. Name and address of person who co	condition cause of death (II	lem 23a) (Type Print)	D36	766		September	2 27	, 2000		
	ZILS		20 NATIONAL 1		VALE -	MD 21502	2					
	State Registrar	31. Date SEP 27 9 2000	32. Registrer's Sig					77.19				

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					State of N	naryland		cate of	Health and M Death		glene Reg. No.	3	2446
	T Belowers		1. Decedent's Neme	(First, Middle, Las	11)					2. Dete of De Month		Year	3. Time of Death
	Physic: /Medic		Martha E. I	Hewit						Octobe			1640
0	Examin	9.0	4a Facility Name (If I	not institution, give	street and number	7)			4b. City, Town, or L	ocation of Deat			
			Sacred Hea	ırt Hospital					Cumberland	1	Allega	ny	
Г	Funerat Director		5. Social Security Nuc. 219-52-040	1 1	TH ONE	Age (In yrs. las		Under 1 Year nths Days		8. Dete of Bir (Month, De 12-Dec-		9. Birthpl Count	ece (Stete or Foreign ry) and
	ahow		Usual Residence of E 10a. State	10b. County		10c. City,	Town or Locatio	n				10	Od. Inside City Limits
	Many Pi	jo	Maryland	Allegar	ny	Frostb	ura						10 Yes 2□No
	7.28 	Directo	10e. Street and Numi			110310		X. Zip Code			10g. Citizen of W	hat Coun	ry?
	th wit	G		TTT night	Sileer			21532-1	624		U.S.A.		
	deat	Funeral	11. Marital Status		12. Wes Deceder Armed Forces	t Ever in U,S.	13. Was I	Decedent of I	Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No	- 14. Race	- America	
21215-0020	72 hours after death with the Maryland natural", or Items 23s or 28s-1 show dreat Elamines mail be notified at	by	1 Never Merried 3 Widowed 4		1 Yes 20 If Yes, Give Year or Dates	No		es 201 No		rnoan, etc.)	Specify:		ng.
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218		Completed	Elementary/Second	y only highest grad dary (0-12)	College (1-4o	r 5+)	life. DO N	OT use retire	pation during most of work ad)	ang			
	should be filed within and Mental Hygiena. marked other than imatic event, tre Ha	5	12		0		Dietary S	upervis	or		Food Indust	ry	
Pu		Be	17. Father's Neme (F	irst, Middle, Last)					18. Mother's Nam	e (First, Middla	Maidan Sumame)	
Maryland	should be nd Mental marked o	၉	Arthur Robis						Lucy E. Mo	mis			
Mar	2 2 2 2		19a. Informent's Nen		ype, Print)		19b. Mailing Ad	drass (Stree	t end Number or Ru	ral Route Numb	er, City or Town, 5	Stete, Zip	Code)
	s 1 and of Health Kem 27 other tr		Richard Hev		husband	1-21	111 High S		Fros		Maryland		1532-
Baltimore,	20 2 2				Removel from State	e cen	ce of Disposition netery, cremetor Michael's Co	y or other ple	1	S-Oct-00	Frostburg,		
Balt	permit. Page Department of Important: If any Injury or page.		21. Signature of Fund	eral Sergice Licen	Dur	1			ess of Fecility I Home, 57 F	rost Ave.,	Frostburg,	MD 2	1532
			23a Part1. Enter the	disease, or comp	dications that cause one cause on each	ed the death.	Do not enter the	mode of dyi	ing, such as cardiac	or respiretory e	rrast.		Approximata Intervel Between
	Physician /Medical Examiner	ner	Immediate Cause (Fi disaasa or condition resulting in death)		. Isul	Programa or a	INF	Tano	MATOR	Bar	el	C	Onset end Deeth
Box 68760,	asth certificate be executed effending physician and for use as the buttal-transit	Physician/Medical Examiner	Sequentially list conc if any, leading to imm cause. Enter Underh Cause (Disease or in that initiated events resulting in death) La	ditions, nediata ying jury	c		as a consequence						
	the after	8	Part II. Other signific	ant conditions co	intributing to death	but not resulti	ing in the underly	ying cause gi	iven in Pert I.	23b. Dld	tobacco use con	tribute to	the cause of death?
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Vital Records,	been sign should by		PENSE (El C	مديمه	- ver (Con	200			en eutopsy med?	COF	ra autopsy findings ilable prior to npletion of cause
al Re	ant: The law fillicate has 3 for, page 2 s	Completed	Acreay	WEEK	& Ch	unie!	OPESTAL	الم الم	Puran	10	Yes 2000		leath?]Yes 2□ No
/Ita	75 3 2	Be	25. Was case referre	ASSESSMENT TO THE REAL PROPERTY OF THE PERSON OF THE PERSO	1	D.	AA	l a	26. Place of Dee	th (Check only	ona)		
10	Physic of the control	2	1□Yes april	0	Hospital: 1 Inpat			LI DOX			dence 6 Othe)
Ë	Mr. N. S.	io i	27. Manner of Death 1 DMhural	5 Pending	28a. Date of In (Month, D	lay Year)	8b. Time of Injury	28c. Inju		28d. Describe	how injury occurre	ed	
Division of	Attending r death. sctor: Afte by the fund	Certification:	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be detarmined	28a. Place of In	njury - At hom	Na, farm, street, f		Yes 2 No	28f. Location (Street and Numbe	or or Rura	Route Number,
ā	9492	12220	4 Homicide			etc. (Specify)				City or To			
	A Paris	edical	29s. Certifier 1 (Check only 2 one)	Certifying Phy	rsician: To the bes iner: On the basis and manner	t of my knowle of examination mand.	edge, death occi n and/or investig	urred et the ti ation, in my	ime, date end place, opinion, death occur	end due to tha red et the time,	causa(s) and mar date end place, a	nner as st nd due to	ated. the cause(s)
	To the To the comple	2	29b. Signature and tit	to of contilior	12	1	,	29c. Licen	se number		29d. Date signed	(Month, I	Dey, Year)
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	Sta Registra		31. Date filed (Vent)	0 5 2000		tras's Signatur	/.	book			· J d	00	
	100				/		14	vous					

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Kuryland Allegany Frostburg

111 High Street

21552-1624 U.S.A

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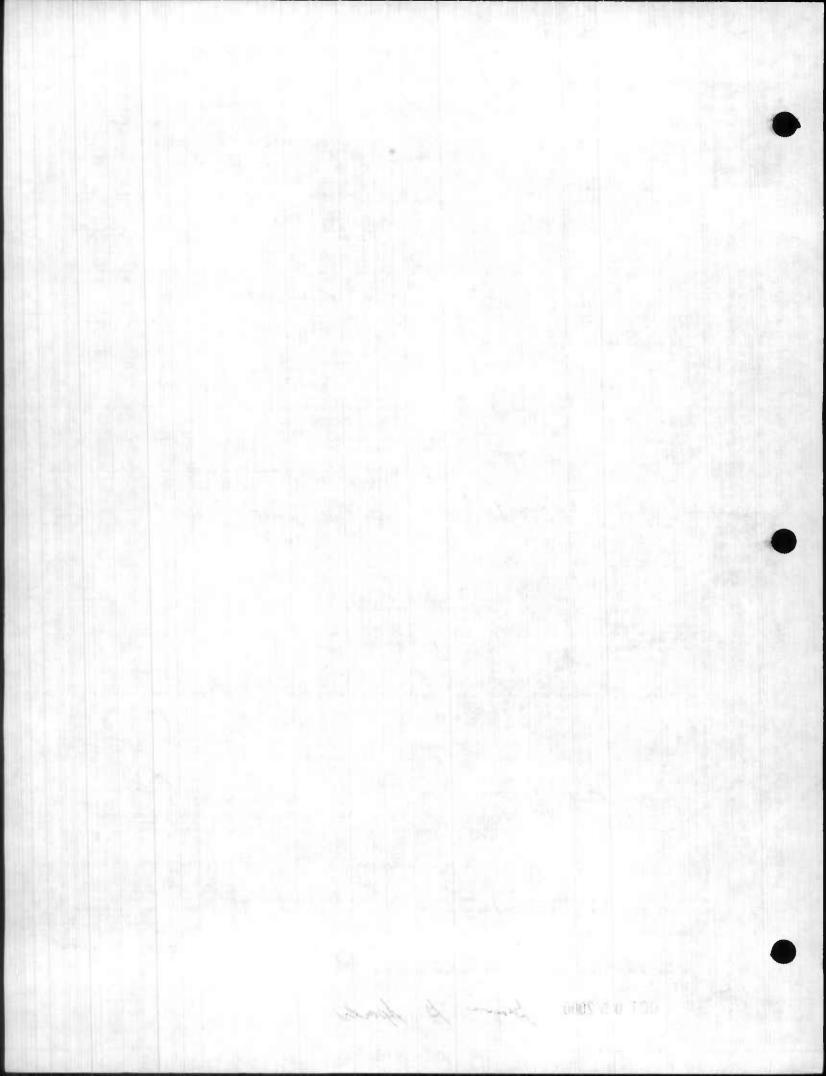
Durst Funeral Home, 57 Frost Ave., Frodburg, MD, 21302

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State of Maryland / Department of Health and Mental Hygiene

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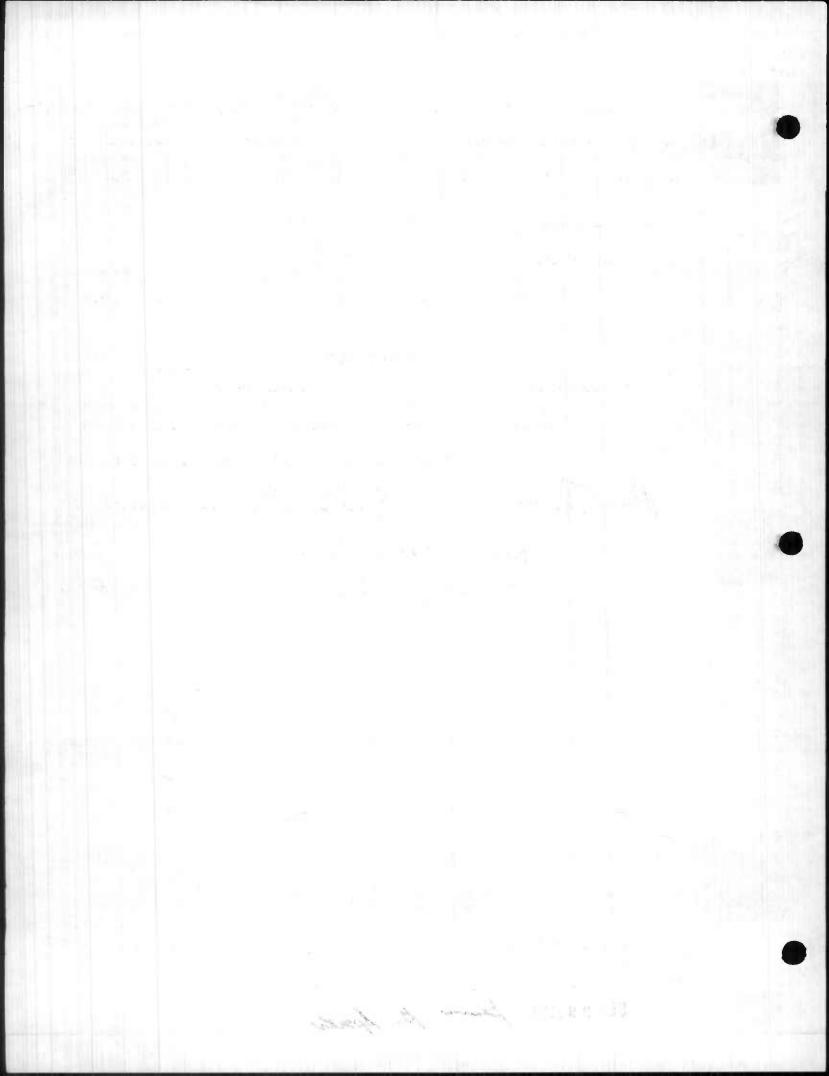
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	525 Glenburn Ave						12			US			
	11. Marital Status	t Ever in U,	21613 J.S. 13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto										
	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces	If Yes, specify C					Rican, etc.)		Bleck, White, etc. Specify: Whit			
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Be Completed	15. Decedent's Ed (Specify only highest gra		16a. Decedant's Usual Occupation (Giva kind of work done during most life. DO NOT usa retired)					ing	16b. Kind of	Kind of Business/Industry			
E C	Elamantary/Secondary (0-12)									wri aa			
Ü	17. Father's Name (First, Middle, Last)			etter C	all.		ar's Name	Postal Servic e (First, Middle, Maidan Sumama)			LAICE		
ToB	Stanley Hunsic	ker					Eva	M. I	Peters				
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		Daughter											
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	21. Signature of Funeral Service Lien		Œ	uai					10/2/00	Harlov	ET IM	r. FA	
	Thomas Funeral Home, P.A.												
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Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

32. Registrar's Signatura B. Aparts



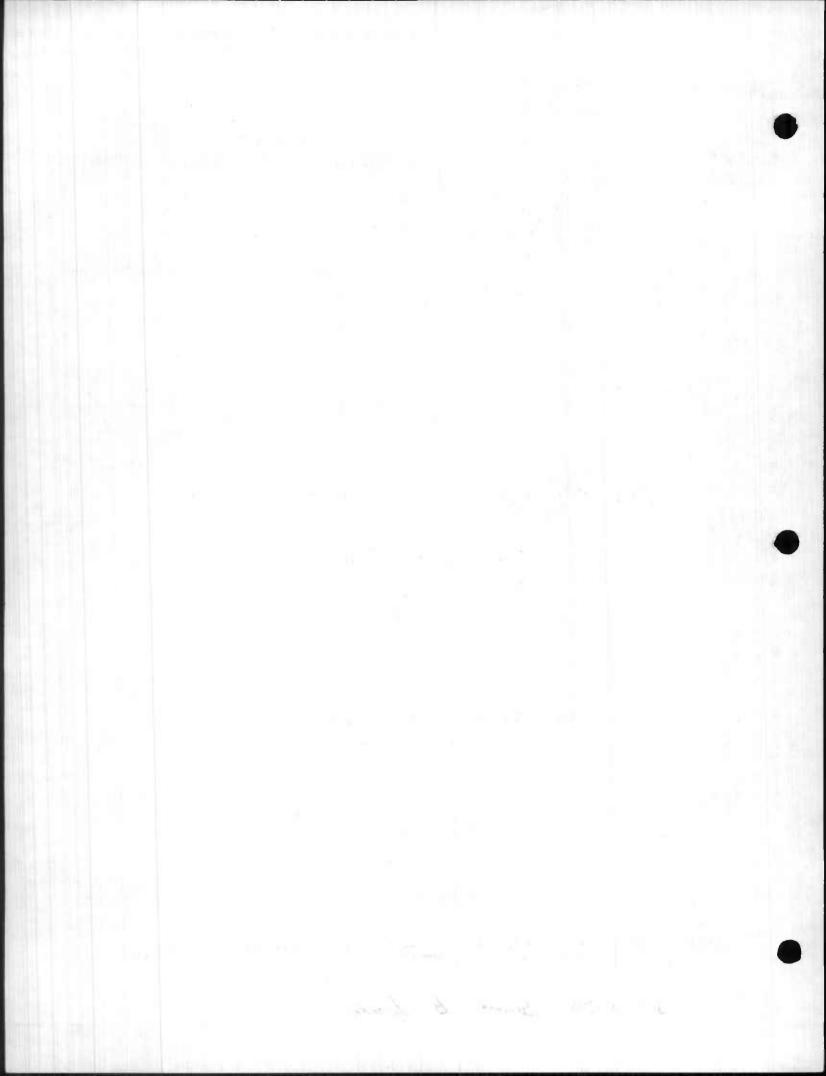
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** HARRY HOMER OCTOBER 2000 9:00 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner GOODWILL MENNONITE HOME GARRETT GRANTSVILLE Hours Min. 8. Date of Birth (Month, Dey, Yeer) If Under 1 Year 5. Sociel Security Number Sex 2 F 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** Days Yrs. 80 1919 MARYLAND 217-10-1662 **Director** Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any or other traumatic event, its Medical Evans or must be notified at 10e. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes ANNO Directo MARYLAND ALLEGANY CUMBERLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 13505 BRISTOL DRIVE S.W. 21502 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? XXYes 2□ No If Yes, Give Year or Dates1 943-1944 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2€No Specify: by Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) KELLY SPRINGFIELD TIRE CO. TIRE MANUF. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) JOHN DAVID JONES ALVERNA ELLEN MCBRIDE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) DARLENE RECKLEY DAUGHTER 7595 JENN DRIVE WOODBINE, MARYLAND 20b. Place of Disposition (Name of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. SUNSET CEMETERY OCTOBER 5, 2000 CUMBERLAND MARYLAND 21. Signature of Funeral Servica Licensee 22. Name end Address of Fecility MERRITT-ADAMS FUNERAL HOME P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heart failure. List only one cause on each line. Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed bunel-transi Sequentially list conditions, if any, leading to Immediele cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lest pue Due to (or es e consequença of) Records, P.O. Box 68760. Physician/Medical the Due to (or as a consequence of) 88 o signed by the ail Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 □ Probably 4 □ Unknown by 24b. Were eutopsy findings eveileble prior to page 2 should Completed 24a. Wes en eutopsy peen completion of cause of deeth? certificate has 1 Yes 21 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: After this certifica director, 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpetient 3 DOA funeral 28a. Date of Injury (Month, Dey Yeer) 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Netural 1 Yes 2 🗆 No 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Certifying Phyeicien: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) end menner es steted.

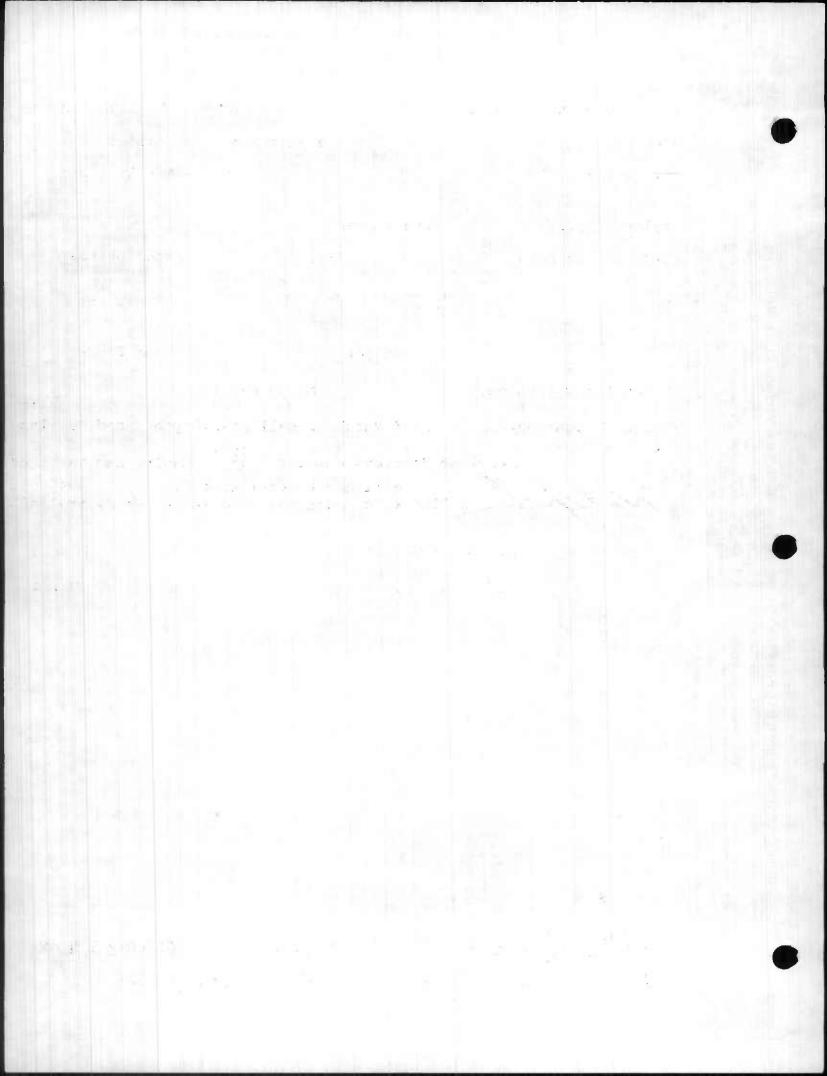
2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) end manner steted. 29a, Certifier Medical 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0014328 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Meyersonle, Pa. 15552 DO 2 Martin 32. Registrar's Signature 2000 State

Registrar



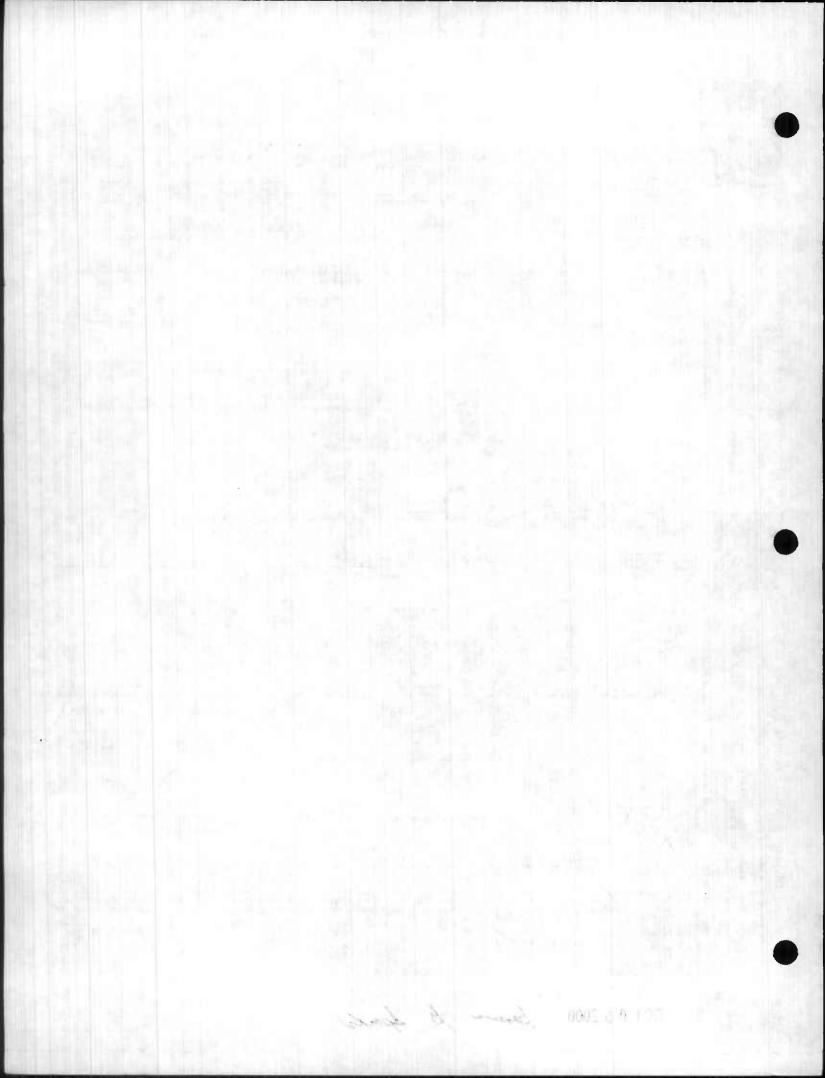
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	Physicia /Medica	n al	Thomas Gibbons Johnson										er 2,	Yaar 2000		
	Examine	er	4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death													
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it. P	Important: If item 2: any injury or other once.	-	4 □ Donation 5 □ Oth 21. Signature of Funeral Sec			ryıa	na				netery	2000		enhar	n, Mary	Lanc
permit. F	any Ir		21. Signatura of Funaral Sarvica Licansaa 22. Nama and Address of Facility Williams Funeral Home, P.A. 20640 M00668 4270 Hawthorne Road, Indian Head, Maryland													
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tha de	y the	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of				
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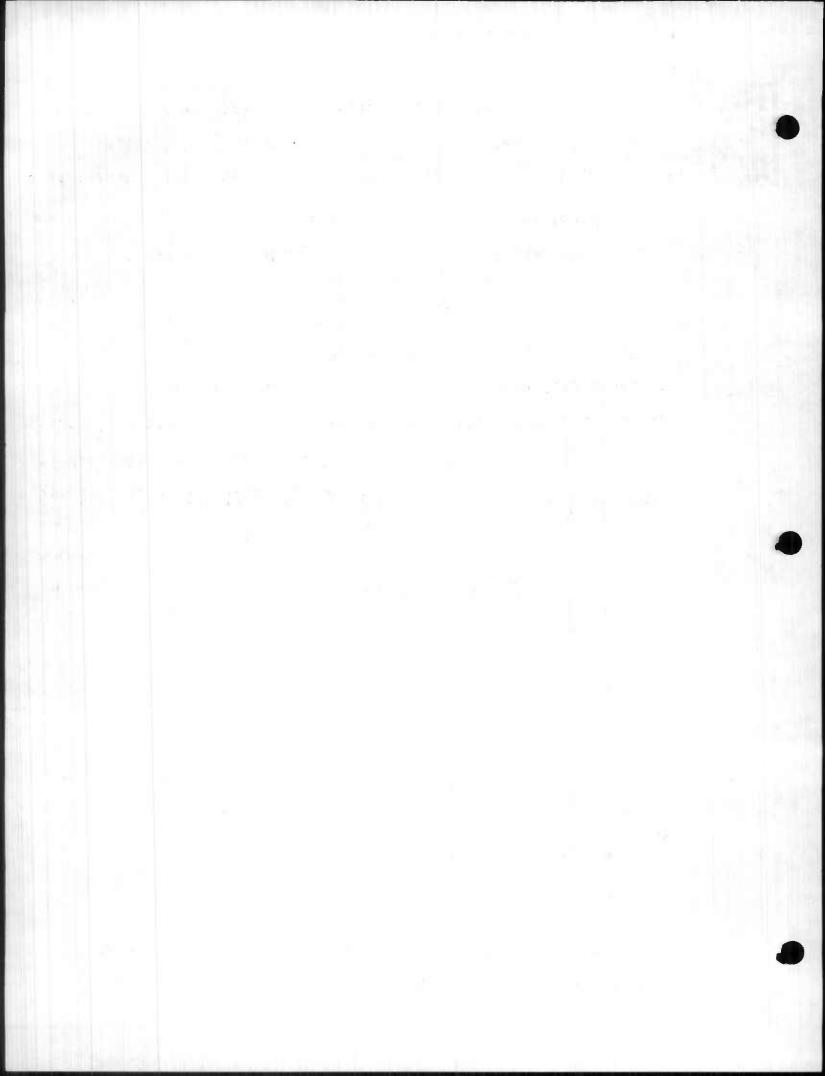
State of Maryland / Department of Health and Mental Hygiene 00-32451

	Certificate of Death	F	Reg. No.		to TOT
	1. Decedent's Neme (First, Middle, Last)	2. Date of Dee Month		Yeer	3. Time of Death
hysician /Medical	MYRTLE MAE KESNER	OCTOBER		00	16:30
xaminer	4e Fscility Name (If not institution, give street and number) 4b. City, Town, or Lo	ocation of Death	4c. County o	f Death	
	Memorial Hospital & Medical Center Cumberland		Allega	ny	
ineral	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 1 M 2 F 7. G Yrs. Months Deys Hours Min.	8. Dete of Birtl (Month, De)	h		ece (Stete or Foreigny)
ector	215-20-6325	MAY 1	1924	MARY	/LAND
	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location			10	d. Inside City Limit
rai Director					1∭Yes 2□N
Director	MARYLAND ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code		10g. Citizen of Wi	hat Count	n/2
			F 17 T	nat Ocum	,,,
era	224 GLENN STREET APT 1 21502 11. Maritel Stetus 12. Wes Decedent Ever in U,S. 13. Wes Decedent of Hispenic Origin? (Spi	ecity Ves or No-	USA 14. Race	- America	n Indien
Funeral	11. Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Never Merried 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No 1 □ Yes 2 □ No	Rican, etc.)	Bleck	, White, e	
by F	3 ☑ Widowed 4 □ Divorced Yeer or Detes:		Specify:	WH	ITE
	15 Decedent's Education 16a Decedent's Usual Occupation		16b. Kind of Bus	iness/Ind	ustry
Completed	(Specify only highest grede completed) (Give kind of work done during most of work life. DO NOT use retired)	ing	FIBER	/TEV	TILE
EO	Elementery/Secondary (0-12) College (1-4or 5+) 1 0 DOWN TWISTER		MANUF		
BeC	17. Fether's Name (First, Middle, Last) 18. Mother's Neme	e (First, Middle,			
To B	LOUIS LARK ELLA	UNKNOW	N		
-	19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Run			Stete, Zip	Code)
	NORMA HUTSON - DAUGHTER 12328 SHADOE HOLLO	W RD N	E.BUMBI	ERLA	ND.MD
	20a. Method of Disposition 20b. Plece of Disposition (Neme of	Dete	20c. Location - C	City or To	vn, Stete 215
	1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)	RDENS	LAVALI	- MD	21502
	21. Squeture of Funeral Service Licensee 22. Name end Address of Fecility	ROLKO		_ ,,,,	21002
	HAFER CHAPEL OF	THE H	ILLS MO	ORTU	ARY
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	WY LAV	ALE, MD	215	0.2 Approximate
an	shock, or heert failure. List only one ceuse on each line.				Interval Between Onset end Death
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er	disease or condition resulting in deeth) s. CEREBROVASCULAR ACCIDENT			1	
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n: T		28d. Describe I	now injury occurre	ed	1 1 1 1 1 1
atio	1 Neturel 5 Pending (Month, Dey Year) Injury Work? 2 Accident investigation M 1 Yes 2 No				
Certification:	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox	Street and Number	r or Rure	Route Number,
Cert	Uniquity, start (3 paciny)	Only or You	vii, Ototoj		
al	29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place,				
pa	one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurrence on the property of	red et the time,	dete end place, e	na aue to	tne cause(s)
	29b. Signeture end title of certifier 29c. License number		29d. Dete signed		
	1/ Vm 1 D36766		Octob	2 5	1 2 W
	30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)				E, Elejaj
1					
	31. Dete filed (Month, Dev. Year) 32. Registrer's Signeture				
Medical Cert	(Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurrence on the basis of examination end/or investigation, in my opinion, death occurrence on the control of the control of end from the cont	red et the time,	dete end place, e	(Month, I	the cause



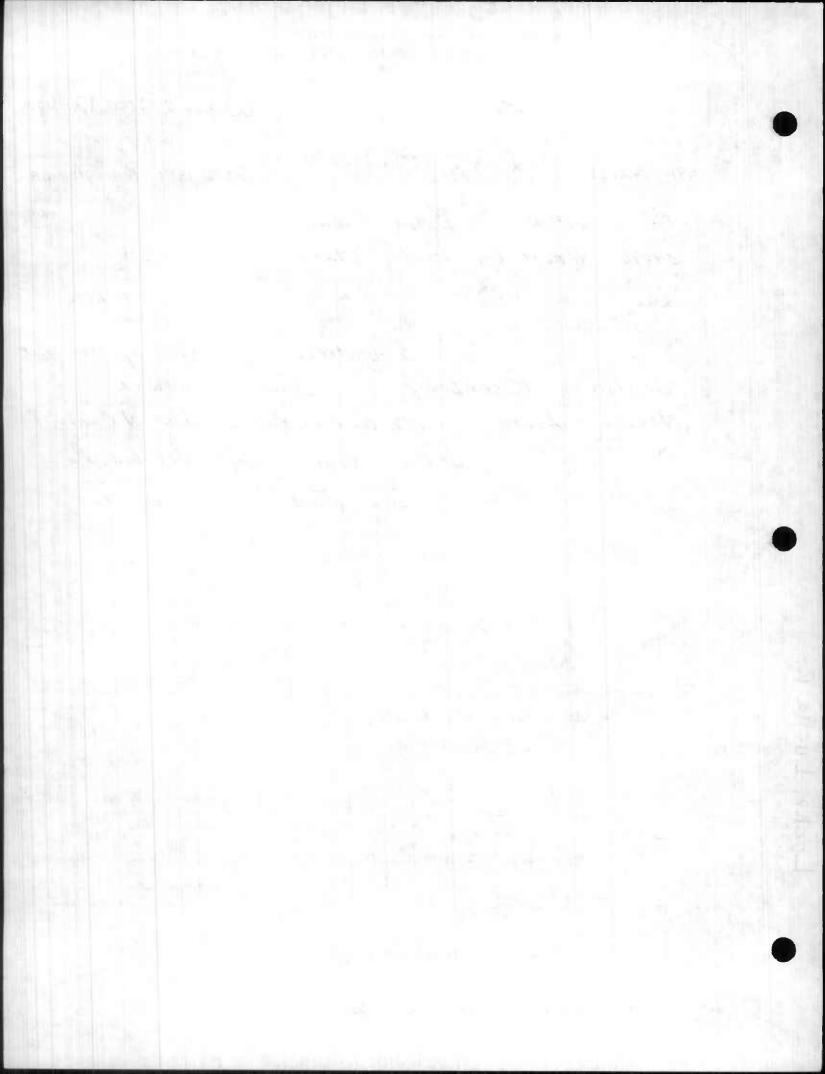
State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 4 5 2

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		1. Decedent's Name (First, Middle, L		NU		77.71		2. Date of Dee	th	3. Time of Death
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xamine	_	4a. Facility Name (If not institution, g	ive street end number)				4b. City, Town, o	r Location of Death	4c. County	
		21840 Water	Street				Pres	ton	Car	oline
neral	1		Sex 7. Age		st birthday)	If Under 1	Year if Under 24 Hr Days Hours Min	n. (Month, Day	Year)	Birthpiace (State or Foreig Country)
ector		159-16-0489 Usual Residence of Decedent	1,0,111	Ö	1 Yrs.			06/17		Pennsylvania
		10a. State 10b. County		10c. City	, Town or Loc	cation				10d. Inside City Limit
le de	5	MD Caro	line				Preston			1 □ Yes ACKN
DOT#	rec	10e. Street and Number			-	10f. Zip Co			Og. Citizen of \	
T De		21840 Water	Street				21655	1		States
Evanitive must be notified at	Funeral Director	11. Marital Stetus	12. Was Decedent E	Ever in U,S	6. 13. V	Vas Deceden	f of Hispanic Origin? (Cuban, Mexican, Pue		14. Rac	e - American Indian,
mine a	F	1 ☐ Never Merried 2 ☐ Married	Armed Forces? 1 □ Yes 2 □ N If Yes, Give	lo				erto Hican, etc.)		ck, White, etc.
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deal	Completed	15. Decedent's E (Specify only highest gi	ducetion rade completed)		16a. Deced	lent's Usual C kind of work	occupation fone during most of w	orking	16b. Kind of Bu	usiness/Industry
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THE COLUMN		12 17. Fether's Name (First, Middle, Las	41		Sgt.	Мај	or USMC	(Final ARA)		·
or other traumatic event, the Med	ă l	Lawrence Cla	,					ame (First, Middle,		10)
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traur		19a. Informant's Name/Relationship Millicent Ma		+			treet end Number or F			
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any injury or other tr		1 ☑ Burial 2 ☐ Cremation 3 I			-	etory or othe				
any injury	-	4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		Ųu			Address of Fecility	10/10	Quant	ico, Virgini
any ir		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	()	_				ns-Esko	w Fune	eral Home PA
	-	Mullay -	Iskow	the death	P	O Box	(43, Fed	leralsbu	rg, Mi	eral Home, PA 21632
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should	Completed							24e. Wes a	in autopsy med?	24b. Were autopsy findings available prior to
3e 2 st	ble									completion of ceuse of death?
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ō	0	25. Was case referred to medical examiner?	No. 2012				-	eath (Check only or	ne)	
ip F		1 ☐ Yes 2 No	Hospital: 1 Inpatier	-	R/Outpatient		-	Home 5 Resid		
d in by the funera	Ö	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury		Injury at Work?	28d. Describe h	ow injury occur	red
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in by		4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At hor . (Specify)	ne, tarm, stre	et, factory, o	flice	City or Tow	n, State)	er or Rurel Route Number,
D		29a. Certifier 12 CertifyIng P	huntelen. To the heat of	6 mu know	todae deeth	annuard at t	ha tima data and star	and due to the	(-)	
	2		hysician: To the best of miner: On the basis of and manner stat	examination	on and/or inv	estigation, in	my opinion, death occ	curred at the time, of	ause(s) end ma late and place,	and due to the cause(s)
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			Certificate of	Death	Re	g. No.	
	1. Decedent's Name (First, Middle, Last,		But I S		2. Date of Death		3. Time of Deeth
Physician (Medical	LUELLA R C	OCKE		Telephone Inc.	DC tobe	2, 2000	12:46pm
/Medical Examiner	4a Fecility Neme (If not institution, give	street and number)		4b. City, Town, or Lo		4c. County of Death	
	WASHINGTON CEN	INTY HUSPITAL		HAGERSIN	ren	WASHIN	161010
Funeral	5. Social Security Number 6. Set	7. Age (In yrs. las	t birthday) If Under 1 Yea Months Days		8. Date of Birth (Month, Day,	9. Birthp	lace (State or Foreign
Director	181-07-2138	M 2×F 80	Yrs. Months Days	Hours Min.		1016 V	sylvania
2 .	Usuel Residence of Decedent	40-02-7					
aryta dist	10a. State 10b. County	10c. City, 1	Town or Location			1	0d. Inside City Limits 1 ☐ Yes 2 No
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nar osen with the Ma r Herm 23a or 28a-f s Wher must be notified Funeral Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cour	itry?
E 52 E	34096 GRE	nt love Re	1 1 1	215		USA	
and and	11. Marital Status	12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Spo ban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Americ Biack, White,	
	1 Never Merried 2 Merried	1 ☐ Yes 2 X No If Yes, Give	1 ☐ Yes 2 No			Specify: 1, 7	Lita
LEER d by	3 Widowed 4 □ Divorced	Year or Dates:				a.	1116
ygiene. ver then "natur it, the Medical. Completed	15. Decedent's Edu (Specify only highest grade		16a. Decedent's Usuai Occu (Give kind of work don)	during most of work	ing 1	6b. Kind of Business/In-	dustry
and and	Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retir			11.11	~ 1
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don don	17. Father's Neme (First, Middle, Last)	7		18. Mother's Name	e (First, Middle, M	1	
Menta arricad affic av	Denton	Kosenber	7	JANE	w	ARNICK	
la man	19a. Informant's Name/Relationship (Ty	1	19b. Mailing Address (Street	- 10	,	City or Town, State, Zip	
n 27	NORMAN L			ork Kons			28698
2 9 9	20a. Method of Disposition	cam	e of Disposition (Name of etery, crematory or other pi	ace)	Date 2	20c. Location - City or To	own, State
The state of	1 ■ Buriai 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		Cabins Cer	n. 11	0/4/00	Bt. Cabins	PA.
orts of	21. Signature of Funeral Service Licanse		22. Name and Add	ress of Facility	_	al Home	1.
8558	James &	the second	GROVE -	Bowerson	, tuner	Al Home	0
	23a. Part1. Enter the disease, or compli	cations that caused the death		road 37		nesboro t	Approximate
	shock, or heart failure. List only or	ne cause on each tine.			or roop notory and		Intervel Between Onset and Death
hysician /Medical	Immediate Cause (Final	7.	0				
xaminer	disease or condition resulting in death)	BRAINSTE	m STROKE	9			
1 to			s a consequence of):				
n and ial-transit Examiner		. HEMURRAMA		13/14c 11/6	11457471	C DISEASE	
ician and bunial-transit al Examir	Sequentially tist conditions, if any, teading to immediate	Due to (or a	s e consequenca of):		,	100	
ician buria	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	MIFFUSE	SUBARAC	HNO:10 17	EMURRI	ANOC	
physicie is the bu	that initiated events resulting in death) Last	Due to (or es	a consequence of):				
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igned by the attending be detached for use at by Physician/Me			THE REAL PROPERTY.				
the hed y	Part II. Other eignificant conditions con	tributing to death buf nof resulting	ng in the underlying cause of	iven in Part I.	23b. Did to	bacco use contribute t	the cause of death?
Phy Phy	HISTORY OF	COLUN CANE	to.		1 □ Ye	e 2□No 3□ Pro	bably 4 Unknow
be del	- 1111111	COEUTE CITIE					
ate has been signed by the attendi page 2 should be detached for us. Completed by Physician/					24a. Was ar perform	n autopsy 24b. W	ere autopsy findings aitable prior to
2 sh						CC	mpletion of cause death?
age 2	Manager 1 and 1 and 1 and 1				1□ Ye	s 2 10 11	JYes 2□ No
	25. Was case referred to medical			26. Place of Deet			
certific irector.	eveminer?	lospitat:	VOutpatient 3□ DOA	ther:		nca 6 □Other (Specif	641
6 -	27. Manner of Death					w injury occurred	97
ector: After by the funer iffication	1 Naturel 5 Pending	28a. Dete of Injury (Month, Day Year) 25	Injury W	ork? ☐ Yes 2 ☐ No			
death.	3 Suicide 6 Could not be	One Diese of Leiter. At home			28f Location /Str	reet and Number or Run	al Route Number
after deat Director: I in by the ertifica	4 Homicide determined	28e. Placa of Injury - At home building, etc. (Specify)	e, farm, sfreet, factory, offic		City or Town		arriodo rambor,
n 24 hours after death. • Funeral Director: After the platety filled in by the funeral edical Certification:					100		
within 24 hours at To the Funeral Completely filled	(Check only 2 Medical Examin	sician: To the best of my knowle ner: On the basis of examinetion					
within 2 To the F complet	one)	and manner stated.					
within 24 hours a To the Funeral C completely filled	29b. Signature end title of cartifier	STAFF		nse number	29	9d. Date signed (Month,	Day, Year)
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	30. Name and address of person who co		Ra) (Type Print)				
	JCAKUSO MO	11110 MEDICAL C	APARUS ED S	4175 127	11:4000016	ness MID	21742
State	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	0 4 1	.1			
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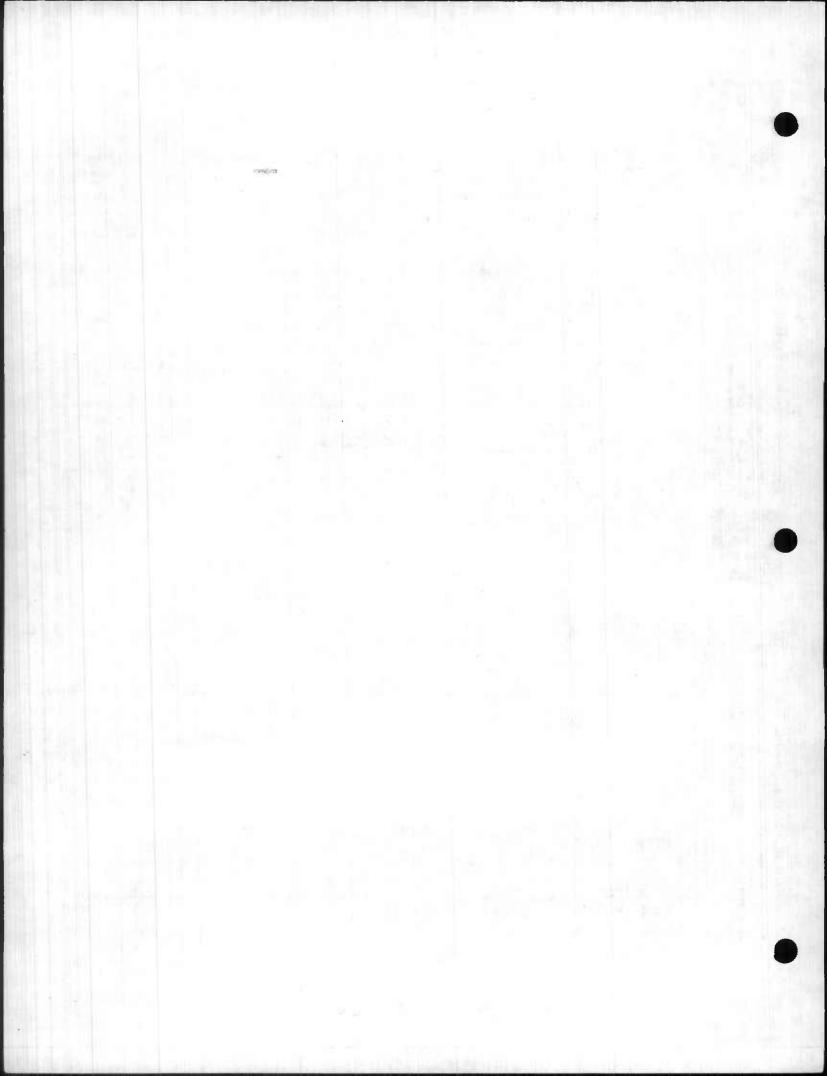
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death Month **Physician** FLOYD KENNETH MINNICK, SR. September 27,2000 7:54 PM /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Julia Manor Nursing Home Hagertown Washington County If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Deys 217-18-7117 1 XM 2 F 81 Yrs. 7, 1919 Director Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Insida City Limits 28a-f show traumetic avent, the Medical Examiner must be notified at MD Washington Hagerstown 1 ☐ Yas 2 X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 21740 U.S.A. 18448 Woodside Drive "natural", or items 23s Funeral death 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indian, pernit. Peges 1 and 2 should be filled within 72 hours after of Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or the important: if them 27 is marked other than "natural", or the any injury or other treumatic event, the the contract of the any other treumatic event, the theory of the any other treumatic event, the theory of the any other treumatic event. Bleck, White, etc. 1 Tyes 2 □ No If Yes, Give Year or Dates: 1 Nevar Married 2 Merried Baltlmore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Education Maintenance Board of 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Nema (First, Middla, Last) Harvey Nelson Minnick, Sr. Anna Shafer 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Marvene Alicia Minnick/Wife 18448 Woodside Drive, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 € Buriel 2 Cramation 3 Ramoval from State Blairs Valley Cemetery Sept. 30 Clear Spring, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service License 22. Name end Address of Fecility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 callions that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, 23a. Pert1. Enter the di-shock, or heart fail Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examine Examiner physician and the burial-transit or Attending Physician: The law requires that the death certificate be associted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. vostate Carcinon Physician/Medical to (or es e consequence of): 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by the 3 Probably 4 Unknown 1 Yes 2 No RTENSION Records, Àq 24b. Were autopsy findings eveileble prior to should should 24a. Wes an eutopsy performed? Completed completion of cause of death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospitel: Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. fnjury et Work? After 5 Pending investigation 1\ Netural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fundaments. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number of Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated.

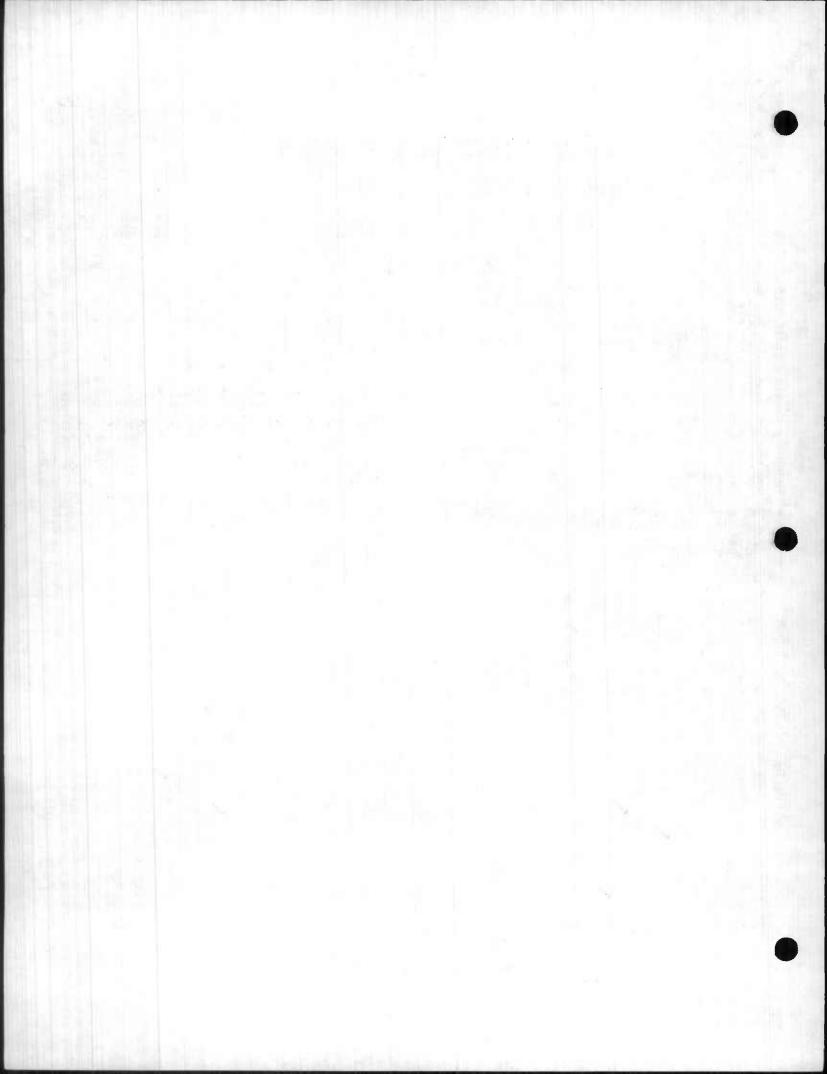
2 Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifiar 29c. License number 29d. Date signed (Month, Dey, Year) 22.16 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) WASERM, 333 Mill Street, Hagerstown, Maryland 32. Registrar's Signeture State 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene

Cartificate of Death

			Ce	ertificate of	Death	F	leg. No.	06400
Physician /Medical	1. Decedent's Name (First, Middle Roger Lee M					2. Date of Dea Month October	Day	Year 5:23 PY
Examiner	4e Fecility Neme (If not institution,	give street and number)			4b. City, Town, or	Location of Death	4c. County	of Death
	38 North Cond	cocheague S	treet		William	sport	Wa	shington
Funeral		6. Sex 7. Ag	e (In yrs. last birthday		If Under 24 Hrs	S. 8 Date of Birth		Birthplace (Stete or Foreign Country)
Director	220-64-6748	XM 2□F	47 Yrs.	Months Days	Hours Min	Dec. 15,	1952	Mary Land
	Usuel Residence of Decedent				1-	1000.15)	1772	Tidi y rano
Men Men	10a. Stete 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
Man 1 st	Maryland Wash	ington	No. of the least o	William	neport			XXYes 2□No
ith the Ma or 28a-1 s or rotified	10e. Street and Number	ringron		10f. Zip Code	iispoi i		log. Citizen of 1	Mhat Country?
A D D	38 North Cond	occhoodus S	troot		21795	100		
72 hours after death with the Maryland naturel; or items 23s or 28s-f show deal Emerical must be notified at each by Funeral Director	11. Maritel Status					Conside Ven er No		JSA se - American Indien,
Per de	1) Never Married 2 Merrie	12. Wes Decedent Armed Forces? 1 \(\text{Yes} \) 200	EVOI #1 0,3.	. Was Decedent of I- If Yes, specify Cub.	an, Mexican, Pue	to Rican, etc.)	Blad	ck, White, etc.
or of by F	3 Widowed 4 Divorced	If Yes, Give	No	1□ Yes 🌂 💢 No	Specify:		Specify	/: • I
in 72 hours i "neturel", deted by		Year or Detes:						White
	15. Decedent's (Specify only highest	grade completed)	(Giv	edent's Usuel Occup e kind of work done	during most of we	orking	16b. Kind of B	usiness/Industry
within ione.	Elementary/Secondary (0-12)	College (1-4or 5	5+)	DO NOT use retire				
al Hygie other t vent, th	11		E	quipment (_			nicipality
d out H	17. Father's Name (First, Middle, L	ast)			18. Mother's Na	me (First, Middle,	Maiden Suman	10)
should be and Mental or umaric eve	Paul Mort,	Sr.			Mary I	ouise Ti	mmons	
P E E	19a. Informent's Neme/Reletionsh	p (Type, Print)	19b. Mai	ling Address (Street	and Number or F	lural Route Numbe	r, City or Town,	State, Zip Code)
Tr. tr.	Linda Reed/Sist	er	329	Linganore	e Avenue	Hagerst	own, Ma	aryland 21740
of other training or other training	20e. Method of Disposition		20b. Place of Disp					City or Town, Stete
y or	1 X Buriel 2 Cremetion 4 Donation 5 Other (Sp.	Removel from State				40 5 00		
permit. Pages 'Department of Himportant: If ite any Injury or of ence.	21. Signature of Funerel Service L	and the same of	Greenlay	Vn Memoria	al Park	10-5-00	William	sport, Maryland
Dem Depa Pny I	Zi. Signature di gariere: Service d			OSDOTNE F	uneral l	Home, P.A		
	leay /	C. CAL						sport, MD 21795
	23a. Pert1. Enter the drouse, or of shock, or heart fallum. List of	omplications that caused nly one cause on each li	the death. Do not en	nter the mode of dyir	ng, such as cardia	c or respiratory arr	rest,	Approximata Interval Between
Physician								Onset and Death
/Medical	Immediate Cause (Final disease or condition	MUM	ardial -	Infact	24			1-70
Examiner	resulting in death)	a	Due to (or es a conse	auneuce og.	29.			1 2
e e				400.100 0.7.				i
physician and is the burial-transit edical Examiner	Conventintly list acaditions	b	Due to (or es e conse	auneuce ug.				
rentricate be executed sing physician and se as the bunal-transit medical Examin	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury			400.000				
sicia buria	Cause (Disease or Injury that initiated events	C	Due to for an a conse					
g phy as th	resulting in death) Lest		Due to (or es a conse	quence or).				
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es that the death certiful igned by the attending to be detached for use as by Physician/Me								
0 0 %	Pert II. Other significant condition	s contributing to death be	ut not resulting in the	underlying cause giv	ven in Pert I.	23b. Did to	obacco use co	ntribute to the cause of death
requires that the neen signed by the hould be detached by the stack of the signed by the stack of the signed by the stack of the signed by the stack of the signed by the						1)(1)	es 2 No	3 Probably 4 Unknow
b bed								
The law require sate has been significant page 2 should Completed						24a. Was a perfor	n autopsy med?	24b. Were autopsy findings available prior to
_ D & _						94		completion of cause of death?
page Com						1 D Y	es 2 No	1 Yes 2 No
dicat	25. Was case referred to medical				00 84		7)	10 100 20 100
certificant rector	examiner?	Hospitel:		Ott	200	eath (Check only or		
Physician: this certific rel director, TO Be (1 Yes 2 No	1 LI Inpatie		ent 3LI DOA	4 LI Nursing	Home 5 Resid		
Term no	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injui (Month, Da)	Year) 28b. Time Injury	Wor		28d. Describe h	ow injury occur	red
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification.	2 Accident Investige			M 10	Yes 2 No			
rect rect by	3 Suicide 6 Could no determin		ury - At home, farm, s c. (Specify)	treet, fectory, office		28f, Location (S City or Tow		per or Rural Route Number,
tal or Attending P is after death. el Director: After t led in by the funerc Certification:			,,					
hour hour ly fill	29e. Certifier 1 Certifying	Physician: To the best of	of my knowledge, dea	th occurred et the tir	me, date end plac	e, and due to the c	ause(s) end me	anner as stated.
to the proposal of Apparenting Projectors: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	(Check only 2 Medical E	caminer: On the basis of and menner sta	examinetion and/or is	nvestigation, in my o	ppinion, death occ	urred at the time, d	late end place,	end due to the cause(s)
Withir Somp	29b. Signeture and title of certifier	/		29c. Licens	se number	2	9d. Date signe	d (Month, Day, Year)
- 3 - 0			- M.	D 1-5	6412		10/14	100
	AA MANAGEMENT AND AND AND AND AND AND AND AND AND AND	(-		- 10 00	0 117.		10/04/	
	30. Neme and address of person w		eath (Item 23a) (Type	Print)	KIX A	500 11	-1/1-	21795
	Sanjay Sax	/		3 Dyr	VII 1)	ive W	11/1/1951	pal, I'U
State	31. Date filed (Month, Day, Year)	4 2000 A	r's Signature	4 lan	. 1.			21795
Registrar	CCI U	± 2000	1	~ papa	us			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** HARVEY MILLER JUNIOR 259 October 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hagerstown Washington
5. Social Security Number Hospital 9. Birthplace (State or Foreign County If Under 1 Yeer 8. Date of Birth (Month, Dey, 7. Age (In yrs. last birthdey) **Funeral** Months Days Hours 12 M 2□ F 220 16 0350 Yrs. Director Greensbu Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Meryral ment of Heelth and Mentel Hygiena.
ant: if Itam 27 Is marked other than "natural", or Itama 23a or 28a-f ahov ury or other traumatic event, the Medical Examiner must be notified as 28a-fahow 1 Yes 2 No mithsburg Director Washington 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3331 reensburg 215A. 21783 Funeral 14. Raca - American Indian Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 1 ☐ Yes 2 ♠ No If Yes, Give Yeer or Dates: 1 Never Married 2 Merried 1 Yes 2 No Specify. Specity: White þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer tarm inq 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) ahlon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stafe, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Heelth ar important: if Itam 27 la any Injury or other trau Smithsburg Rd A Miller Wite arqurite 13331 Greensburg Md 21783 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removel from State Church Cemetery Washington Net 5 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Grove. Bowerson. Furreral Home 23a. Perti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. 17268 Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardia Zdays Due to (or as a consequenca of): Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): use as the bunal-trer Cardiomy pathy Due to (or as a consequence of) should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?

Ph sician /Medical Examiner

The law requires that the death certificate be executed

signed by

has page 2

this certificata

After

after death.

within 24 hours a To the Funeral C

completely

Medical Certification: To

Hospital or Attending Physician:

To the

Box 68760,

P.0.

Division of Vital Records,

Saltimore, Maryland 21215-0020

Physician/Medical Examiner Be Completed by

25. Was case reterred to medical

31. Date filed (Month, Dey, Year)

5 Pending investigation

6 Could not be determined

Haywood

OCT 0 4 2000

1 Yes 2 No

27. Manner of Death

Natural

3 Suicide

2 Accident

4 Homicide

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

2 No 1 □ Yes 2 □ No 1 Yes 26. Place of Death (Check only one)

Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature end title of certifier

1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11110

32. Registrar's Signature

am

State Registrar medica

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Robert E. McKenzie \$eptember 30, 2000 01:25 PM /Medical 4e Facility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 205 McCulloh Street Allegany Frostburg If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours 100 M 2□ F Yrs. 212-10-6264 Director Maryland 16-Jan-16 Usual Rasidanca of Decedant the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at 14TYes 2□No Director Maryland Allegany Frostburg 10e. Street and Number 205 McCulloh Street 10f. Zip Code 10g, Citizen of What Country? 21532-U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status hours after 1 Nes 2 No If Wes, Giva Yaar or Dates: WW∏ 1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Pages 1 end 2 should be filed within and to the pages 1 end Mental Hygiena.
Int: If them 27 is marked other than "r Elamantary/Secondary (0-12) Collega (1-4or 5+) Spinning Department 8 textile manufacturing 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 27 is marked or traumatic even **Edward Joseph McKenzie** Mary Freal 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene McKenzle Frostburg Maryland 21532-205 McCulloh Street other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Mathod of Disposition 20c. Location - City or Town, State Date permit. Pages 1 Department of H Important: If ite any injury or ot ance. 1 Burial 2 □ Cramation 3 □ Removal from Stata Frostburg Memorial Park 03-Oct-00 Frostburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licenses 22. Nama and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a Partf. Entar tha disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) a. Congestive Heart Failure Examiner 4 days Dua to (or as a consequence of): Examiner Carcinoma of the bladder physician and the burial-transit 5 years thet the death cartificeta be axecuted Sequantially list conditions, if any, leading to immadiate causa. Enter Undarlying Cause (Disease or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): for use es P.O. signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Coronary artery disease Records. by Tha law requires 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy Chronic Obstructive pulmonary disease completion of cause of death? page 2 1 Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physician:
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 Funeral Director: After this certifical lately filled in by the funeral director. Be 25. Was casa rafarrad to medical examinar? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigetion 2 Accidant 6 Could not be determined 28f, Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homlcida 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 hos To the Fune complately fi (Check only one) 294. Date signed (Month, Day, Year) 29c. License number 29b. Signature and titla of certifiar D0024951 120) 30. Nama and addrass of person who completed cause of death (ftem 23a) (Type, Print)
Chang-Hyun Oh, M.D., 48 Tam Terrace, Frostburg, Maryland 21532

Registrar

State

31. Data filed (Month, Day, Year)

OCT 03 2000

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

amend item 8 per fh G788 10/23/00 yf Certificate of Death 2. Data of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** '- /Medical 4b. City, Town, or Location of Death County of Death (If not institution, giva straet and number, 4a Facility Name Examiner 8. Date of Birth (Month, Day, Year CODE. 16, If Undar 1 Yaar Birthplaca (Stata or Foreign Country)
 CA 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months Days 1XM 2□ F 67 Yrs 264-44-4458 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at MD Severna Park 1 Yes 2X No Anne Arundel Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 520 Evergreen Road 21146 USA Funeral daath 12. Was Decedent Ever in U,S. Armad Forcas? Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pagas 1 and 2 should be filed within 72 hours effar a Department of Health and Mantal Hygiane. Important: If item 27 is marked other than "natural; or item any Injury or other traumatic event, the Medical Exemplants 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married aitimore, Maryland 21215-0020 White 1 ☐ Yes 2 No Specify: þ Korea 3 X Widowed 4 ☐ Divorced Completed 15. Decedeni'a Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) Electronic Engineer Engineering 5+ 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Nama (First, Middla, Last) Be James C. McCoy, Sr. Alma Gay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) James C. McCoy, III/Son P.O. Box 904, Londonderry, NH 03053 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Sept 26 Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 2000 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Go not enter the mode of dying, such as cardlac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner physician and the buriel-transit requires that the death certificata be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or es a consequence of) P.O. Box 68760 Physician/Medical Due to (or as a consequenca of): 98 usa for 23b. Did tobacco usa contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ℃ Unknown 1 Yes 2 No signed t Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed page 2 certificete has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? funaral director Be 26. Place of Death (Check only one) 1 Ves Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2□ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 No 24 hours eftar death. 1 Yes Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Partifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.
2 Wedical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titla of cartifian 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Briggs, MD, 2414 Hightee Court, Crofton, MD 21114 31. Date filed (Month, Day, Year) 32 Ragistrar's Signature State

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a Facility Neme (If not institution, gi					4b.			cation of Deatl			
VA MARYLAND HEAD	LTH CARE	SYSTEM				PERR		DINT	CEC.	IL	
003-22-2790	Sex 7	. Age (In yrs. las	Yrs.	Months		Hours	4 Hrs. Min.	8. Date of Bir (Month, Da Sept. 2	, 1919	9. Birth Cou New	place (State or Foraign intry) York
suel Residence of Decedent On. State 10b. County		10c. City,	Town or L	conting							10d Inside City Limite
ou. State 100. County											10d. Inside City Limits
laryland Anne Ar	undel	A	nnapo	olis							1 □ Yes 2 □ No
e. Street and Number				10f. Zip	Code				10g. Citizen of V	What Cou	intry?
11 Ballast Way				2	1401				US	A	
. Marital Status	12. Was Deced	ent Ever in U,S.	13.	Was Deced	ent of His	panic Origi	in? (Spe	city Yas or No			ican Indien,
1 Never Married 2 Married	Armed Ford	□ No		If Yes, speci	37		Puerto	rtican, etc.)	Blac	ck, White	, atc.
3 ☐ Widowed 4 ☐ Divorced	It/Yes, Give Year or Dat	10/1	45	1□ Yes 2	Mo No	Specify:			Specify	<i>/</i> :	White
15. Decedent's E	ducation		16a. Dece	dent's Uşual	Occupati	ion			16b. Kind of Br	usiness/Ir	ndustry
(Specify only highest gr	ade completed)		(Give	b kind of work	k done du	ring most o	of worki	ng			
Elementary/Secondary (0-12)	College (1-4 Vrs.	lor 5+)	1	Analys	t				Federa	1 Gov	vernment
. Father's Name (First, Middle, Last	-					A. Mother	s Name	/First Middle	Maiden Surnam		, 62 11.11.611.6
Charles Whi	•	orris						a Marie		,0,	
9a. Informant's Neme/Reletionship ((Type, Print)		19b. Maili	ing Address	(Street an	d Number	or Rura	I Route Numb	er, City or Town,	Stete, Zi	ip Code)
lileen Morris/ Wi	.fe		711 I	Ballas	t Way	An	napo	olis, M	aryland	2140	01
e. Method of Disposition	70		ce of Disponentery, cre	osition (Nam	e of her place)		1	Date	20c. Location -	City or T	own, State
1/12 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia				on Nat			110	0-3-00	Arling	ton,	Virginia
1. Signeture of Funeral Septice Lice	-		2	2. Neme and	Address	of Facility	1				
· White Illuly	-						Fune lane	eral Ho	me dgewate:	r, MI	21037
3a. Part1. Enlar the disease, or com shock, or heart feiture. List only	plications that car	ised the death.	Do not en	ter the mode	of dying,	such as c	ardiac o	r respiretory a	rrest,		Approximate Interval Between
Shoon, or frount foliare. List only	One cause on ear	at mio.								1	Onset and Death
nmediate Cause (Final										1	_
sease or condition sulting in death)	a ASPIRA	ATION PN								1	7 DAYS
		Due to (or a	s a conse	quence of):						1	
	ALZHE	MER'S D	EMEN'	TIA						- i	9 MONTHS
equentially list conditions.		Due to (or e	s a conse	quence of):							
any, leading to immediate use. Enter Underlying	HYPERT	TENSION								- 1	UNKNOWN
ause (Disease or injury at initiated events	c	Due to (or as	s a consec	quence of):						-	
sulting in death) Last										į	
	d										
A II (04) I W A W											
rt II. Other significant conditions of	contributing to dea	in but not resulti	ng in the u	inderlying ca	use given	in Part I.					to the cause of death
								10	Yas 2□No	3 Pro	obably 4 🖾 Unknow
										T	
									an autopsy rmed?	a	Vere autopsy findings veilable prior to
							-				ompletion of cause f death?
								10	Yes 2000	1	□Yas 2□No
. Was case referred to medical						ne Di	40				
axaminer?	Hospital:				Other			(Check only o			
1 Yes 2 XNo	1 12 10		VOutpatie		7	4 D IAUIS	-		dence 6 □Oth		ity)
7. Manner of Death	28s. Date of	BESSET 1 21	Bb. Time o	77 128	ic. Injury a	IT		znd Describe	how injury occur	Tecl	

Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner

To the Mospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trensit

Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

Directo

To Be Completed by Funeral

Funeral

Director

axaminer'		to medicat
1 Tes	2XNo	
27. Manner of	Death	

4 Homicide

1 K Neturel 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide

1 Yes 2 No

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 100 Certifyin 29a. Certifier (Check only one)

29b. Signature

29c. License number D50454

SEPTEMBER 24, 2000

29d. Data signad (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Neme and addr no completed cause of death (Item 23a) (Type, Print)

ARASTOO YAZDANI, VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902 M.D. 31. Date filed (Month, Day, Neer)

State Registrar

2 8 2000

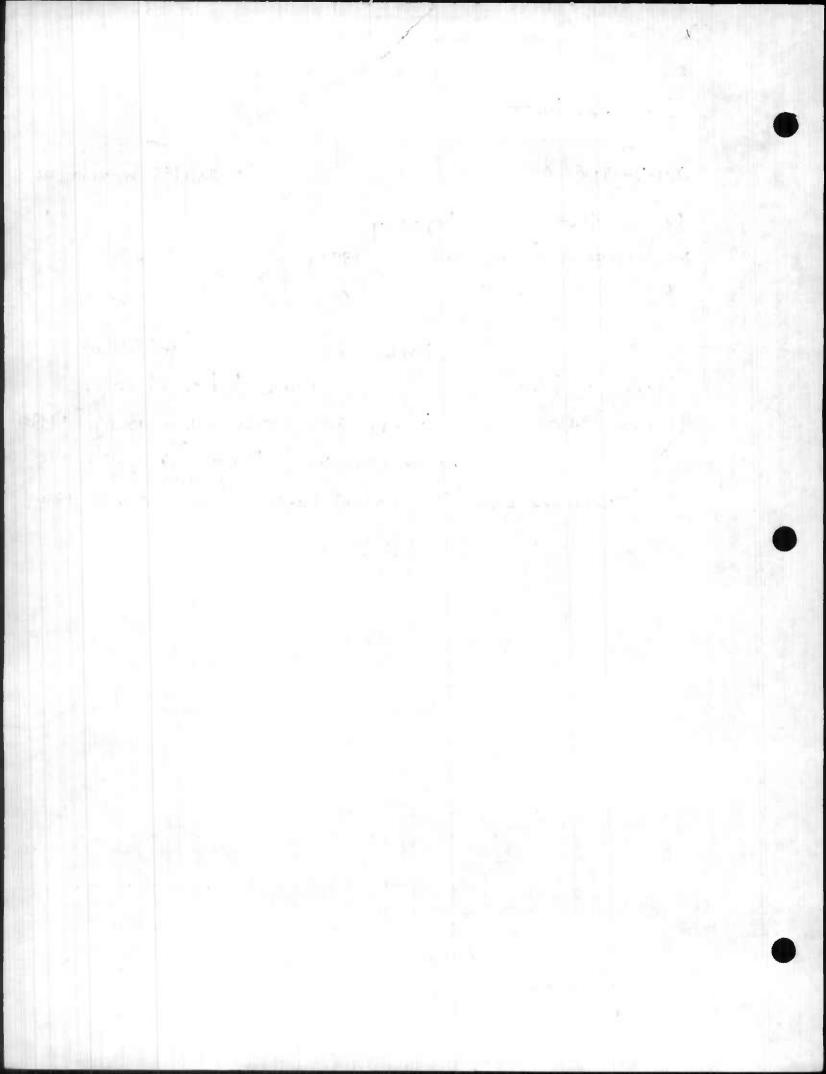


SEP 2 8 2000

CS 00-5700-011 UNKNOWN 00-281 Ivan J. Mast

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

dn J. Mast	Certificate of Death	Reg.	No. () ()	32161
Physician	1. Decedent's Name (First, Middle, Last)		Day Yeer	3. Time of Death
/Medical	IVAN JAY MAST	OCTOBER or Location of Deeth	6, 2000 4c. County of Deat	19:00 PM
Examiner	SANDTOWN BRIDGE AND ROUTE 287 GOLDS		CAROLIN	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	rs. 8. Date of Birth		hplace (Stete or Foreign untry)
Director	221-14-4020 14 118.	Dec 20, 1		OMING DE.
Du B	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
the Meryla 28a-1 ahov notified at				1 ☐ Yes 2 No
the N	10e. Street, and Number 10f. Zip Code	10g.	Citizen of What Co	untry?
h with	64 APPLEGROVE SCHOOL ROAD 19934		USA	
offer deeth with the Mei r ferma 23a or 28a-fa diner must be notified Funeral Director	11. Merital Status 12. Was Decedent Ever in U,S. 13. Wes Decedent of Hispanic Origin? Armed Forces? 13. Wes Decedent of Hispanic Origin? If Yes, specify Cuben, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Raca - Ame Black, White	
O20	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: W	HITE
Ind 21215-0 be filed within 72 ho tal Hygiene. Ind other than 'nature avent, me weden!	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of wife. Do NOT use retired)	vorking 16b	. Kind of Business/	industry
within she.	Elementery/Secondary (0-12) College (1-4or 5+) Farm Worker	A	aricult	ture
and 21 be filed wi htal Hygien d other the avent, tre	17. Father's Name (First, Middle, Last)	łame (First, Middle, Mai	den Sumame)	
Vlan weld be Mental wrked o	Henry E. MAST Rosa	Her	shher	ger
S PEE	19e Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or			
2 5 = 2 E	Henry Mast 64 Applearage S	chool Rd.	WYOMI	ng, De 199:
or Health	20a. Method of Disposition 1 ABurial 2 Cremetion 3 Removal from State 20b. Plece of Disposition (Name of Cemetery, crematory or other place)	Pate 200	. Location - City or	Town, State
Baltimore, semit. Pages 1 el popertiment of Heam moortant: If Neminy Injury or othe Mice.	4 Donation 5 Other (Specify) Amish lemetery	10/10/00	Jover, D	relaware
Baltim pemit. Pag Dependent: Important: I any Injury o	21. Signeture of Funerel Service Licensee 22. Name and Address of Facility €	ol S. Brad	ford St	reet
m goesa	Hillian Corellater Torbert Funer	al Chapel	Dover	De 19904
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	liec or respiratory arrest,		Approximete Interval Between
Physician / /Medical	Immediate Course (Final	0.15		Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) MULTIPLE FNJV	ICIRS		
	Due to (or as a consequence of):			
executed in end instrument Examiner	Sequentially list conditions. Due to (or as a consequenca of):	-3		
60, be executed total end burial-transit				
68760, ifficete be execut g physician end es the burial-trar	that initiated events resulting in deeth) Last Due to (or as a consequence of):			
ing pl				
Box 6 auth certifi ettending for use es			Î	
by the darched inched	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
S, P.O es thet the igned by the be detache		1 Yee	2DINO 3□P	robably 4 Unknow
Vital Records, P.O. Box liden: The lew requires thet the death cert certificate has been signed by the estending rector, page 2 should be detached for use be Completed by Physician M.		24a. Was an a		Were autopsy lindings
v require		performed	d?	availeble prior to completion of cause of death?
Re lev he lev e has ege 2		1 Yes		1)©Yes 2□ No
Vital Ricelan: The breathertor, pege	25. Was case referred to medical 26. Piece of 0	Death (Check only one)		7
Of Vita Physician: this certific ral director,	exeminer? 1 X Yea 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	g Home 5 Residenc		
Jing Phys Affecthis tuneral di		PILKUPTRU	injury occurred P/	ASSENGER OF
VISION Attending or deeth. ector: After by the tune	2 M Accident investigation 10/6/00 530 PM 1 Yes 2 No 3 Suicide 6 Could not be 20 River Figure Figure At home form street lectors office	COLLISION	WITH TRA	CTIRTRAILOI
Division or Attending after deeth. Director: After d in by the tune	4 Homicide Solicide Code Interest Code Interest Code Interest Code	City or Town, S	state) CT Zb+	ural Route Number, AT SANDTOWN
plts	STRUCT 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and old		OLDSBORD	MA
Division C be Hospital or Attanding P in 24 hours after deeth. The Funeral Director. After to pletely filled in by the tuners edical Certification:	29a. Certifier Centifying Physician: To the best of my knowledge, death occurred at the time, date and play Check only one Check only one	courred at the time, date	end pleca, and due	to the cause(s)
Div To the Hospital or / within 24 hours after To the Funeral Dire completely filled in t	29b. Signeture and title of certifier 29c. License number	29d.	Date signed (Mont	h, Day, Year)
F \$ F 0	O.C.M.E.	0	CTOBER 7,	2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		CIODER /	~~~
	MARY G. RIPPLL, M.D. 111 Penn Street, B	altimore, M	laryland 2	21201
State	31 Date filed (Month Day Year) 32 Registrar's Signature			
Registrar	DET 1 1 2000 Nerson B. Sparks			

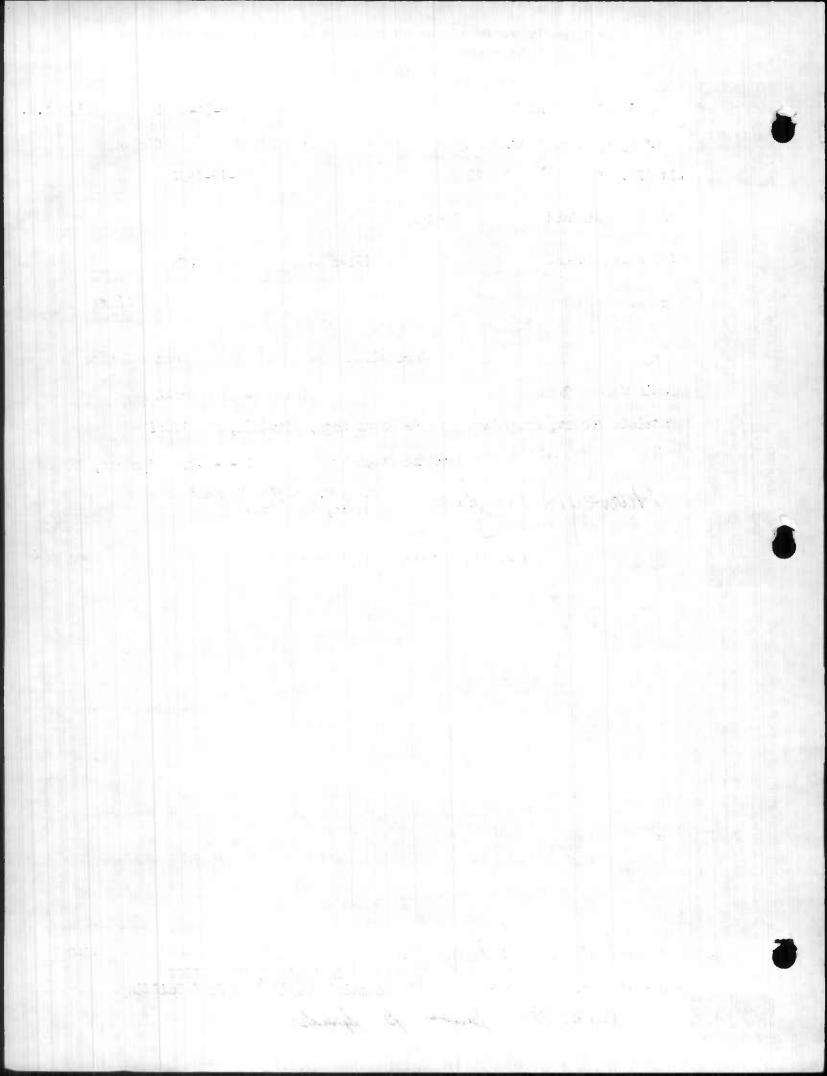


State of Maryland / Department of Health and Mental Hygiene

				Clate of I	nai yiai				Death	Worth Try	Reg. No.	0 3	32462
	Physician	1. Decedent's Neme	E.		2. Data of D Month	eath Day	Year	3. Tima of Death					
Ý	/Medical Examiner	JESSE 4a Facility Nema (If	not institution, giva	NORR street and number				4	tb. City, Town, o	SEPTEMI or Location of Dee		000 y of Death	9:30AM
	Lxammer	DEVLIN M		CUMBERLAND ALLEGANY									
	Funeral Director	5. Social Security No. 705-09-34	48	x DM 2□F	Age (In yrs. 89	last birthday) Yrs.	If Unde Months	Days	If Under 24 Hi Hours Mi				ace (State or Foreign ry) YLAND
	pue &	Usuel Residence of 10a. Stete	Decedent 10b. County		10c. Ci	ly, Town or Lo	cafion					10	d. Inside City Limits
	Meny He He H	MARYLAND	ALLEGANY			CUMBER	LAND						1 ☐ Yes Z\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
	ter deeth with the Meryland Hems 23a or 28s-f show her mast be notified at "uner al Director	10e. Street and Num	nber				10f. Zi	p Code			10g. Citizen of	What Countr	ry?
	e 23a	12513 BED	FORD ROAL							(O'4. V N	U.S.	A . ce - America	in ledies
_	ors after alf, or he by Fu	11. Merital Stafus 1 Never Marrie 3 Widowed		Armed Forces 1 Ves 25 If Yes, Give	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 Year or Dates: 13. Wes Decedent If Yes, specify 1 ☐ Yes 2 ☑ 1 ☐ Yes 2 ☑				Specify:	(Specify Yes of Nerto Rican, atc.)	Special	ick, Whifa, at	tc.
21215-0020	ed within 72 hours ygiene. wr then "neturel", rt, rr Completed by		15. Decedent's Educity only highest grad	de completed) (Give kind of ville. DO NOT			kind of w DO NOT (of work done during most of working OT use retired)			16b. Kind of E		ustry
		17. Father's Nema (First, Middle, Last)			CAR I	NSPE	CTOR-	-RAILROA 18. Mother's N	eme (First, Middle	B&O RAI a, Maiden Sume		
/ian	Mentel H Mentel H arked out artic ever	GEORGE W	. NORRIS						HARRIE	ETT E. A	PPLE		
Maryland	and Mer la marke aumatic	19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or											Code)
	f Heelth fram 27 other to	EDWARD J.			SON 20b. I	Plece of Dispo	sition (Ne	me of		Waynesbo	20c. Location		vn. State
Baitimore,		1 ☑ Burial 2 ☐	☐ Cramation 3 ☐F 5 ☐ Other (Specify)		10	cemetery, cren	netory or	other pled		1,2000			
aiti	permit. Pege Department of Important: If any injury or ance.	21. Signature of Fur			pull	22	. Name a	nd Addre	ss of Facility			Land,	FID
m	SOESS	Do	le Z.	einth		4	04 D	FCATI	IR STREE	T CUMBER	AMD WA	DVT AND	,
e.		23a. Pert 1. Enter th shock, or heer	e disease, or compl t feilure. List only o	ications that ceus ne cause on eech	ed the deat line.	th. Do not ente	er the mo	de of dyir	ig, such es cardi	ac or respiretory	errest,	1	Approximate Interval Between Onset and Death
1	Physician /Medical Examiner	Immediate Cause (F disease or condition resulting in death)	Final	aA	CUTE Due to (c	RES			y Fai	WRE		1	1 DAY
	P = =			b/	ASPIRA	Trav	SYN	DROP	YE.			1	3 DATE
	axacuted in and internsit Examiner	Sequentially list con if any, leading to im-	ditions, madiate			or as a conseq							
68760,	filcate be assecuted a physicien and as the burial-transit edical Examír	Sequentially list con if any, leading to import course. Enter Under Ceuse (Disease or in that initiated events	njury	c. Ce		oVASCE			COUNT	100			6 MONTHS
	25 70 6	resulting in death) L	ast	d	ì								
Box	ires that the deeth cert signed by the attending does deteched for use 1 dby Physician/M	Part II. Other signific	and anditions on	stellusting to doubt	but not so	unitainer in the con-	a et a et a ta e		as in Part I	22h Die	I tobacco use o	antella de la	the cause of death?
Ö	by the teches	Partii. Other signific	Caint Conditions Co.	unbuling to death	DUI NOT 168	oung in the or	loenying	cause giv	en ar Penti.		Yee 2 No		ably 4 DUnknown
	igned be de									_			
of Vitai Records,	sw requisite been 2 should										s en eutopsy lormed?	con	re autopsy findings ilable prior to nplation of causa leath?
aiE	yelcten: The lav s certificate has director, page 2 To Be Comp									1□	Yes 2 No	10	Yes 21 No
5	Physician: this certific ral director, t: To Be	25. Was case referrence examiner?		fospitel:	tion(2	ER/Outpatien	f 3□ D	OA Oth		eeth <i>(Check</i> on <i>ly</i> Home 5 ☐ Res		her /Snecify	1
ion of	Attending Physic death. ector: Attenthis by the funeral di	27. Manner of Deeth		28a. Date of In (Month, E	jury	28b. Time of Injury		28c. Injur Wor			how Injury occu		
T .	구 하는 그	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined							28f. Location City or To	(Street end Num own, Stele)	ber or Rural	Route Number,
	To the Hospital within 24 hours to the Funeral completely filled	29e. Certifier (Check only one)	1X Certifying Phys 2 Medical Exami	sician: To the bes ner: On the basis end manner:	of examina	wiedge, death ition end/or inv	occurred	f et the tir n, in my o	ne, date end pla pinion, deeth oc	ce, end due to the curred et the time	e cause(s) and m , dete end piece	nenner es sta , end due to	ated. the ceuse(s)
- 1	within 2 To the comple	29b. Signeture end t	title of certifier				29	c. Licens	e number ·	29d. Date signed (Month, Day,			Day, Year)
					D 23334 SEPTEMBER 27, 2000					7, 2000			
	mil	30. Neme and addre					- 61						
	State	DR DINESH 31. Date filed Month	B. SHAH	625 KF	ENT AV				ND MARYI	AND 2	L502		
	Registrar	31. Date filed (Mont)	29 2000	Some	wa	4	100	uls	/				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Ma		Certifica				Reg. No.	Ú	240	Ú
Physician	Decedent's Name (First, Middle, L.					2. Dete of De Month	eeth Dey	Year	3. Time o		
/Medical	JAMES WESLEY							2000		0135	a.m.
Examiner	4a Facility Name (If not institution, g					4b. City, Town, or					
<u> </u>	Allegany Coun			Miller	ler 1 Year	Cumberlo		Alle	gany		
Funeral Director	5. Social Security Number 6. 214 07 5350 Usual Residence of Decedent	Sex 7. Age 12 M 2 F 92	(In yrs. last	Yrs. Month		Hours Min.	8. Defe of Bi (Month, Di 6~19~1		MD MD	placa (State ntry)	or Foreign
and w	10a. State 10b. County		10c. City, To	own or Location						10d. Inside (City Limits
4 sh	PA Bedford	d	Hundm	an						1,X) Yes	s 2 No
vith the Mer or 28a-f sl	10e. Street and Number				Zip Code			10g. Citizan of	What Cou	nfry?	
Mitthe San or	142 Water Stree	+		17	5545			440.4			
r items 23s	11. Marifal Stetus	12. Was Decedent E	ver in U,S.	13. Was Dec	cedent of I	Hispanic Origin? (S ean, Mexican, Puer	pecify Yes or N	USA 14. Ra		ican Indien,	
0 0 0		Armed Forces? 1 Yes 2 N If Yas, Give Year or Dates:	lo .		20 No		o Hican, etc.)		ck, White, Y:Whit		
"natural",	15. Decedent's	Education	16	Sa. Decedent's U	sual Occup	pation	4.1	16b. Kind of B			
ed within 72 ho ygiene. er than "naturi it, ir wolcell	(Specify only highest g	rade completed) Collaga (1-4or 5-	+)	life. DO NOT	usa ratire	during most of wo.	rking				
filed within Hygiene. other than ent, it is in e Comp	12			uperviso	17			Manufa e, Maiden Sumar	cturi	na	
be filed d other event,		st)				18. Mother's Na	ne (First, Middle	e, Maiden Sülmar	ne)	3	
Men Men To To	Lewis Wesley Owe	ens				Susan t and Number or Ri	mnu) Ho	tchkiss			
C1 0 m a	19a. Informant's Name/Relationship		1						, State, Zi	p Code)	
s 1 and f Health Item 27 other tr	Patricia Hooker,	daughter		46 Downs	Road	d, Airvil	le, PA	17302			
of His	20e. Method of Disposition 1 🕱 Burial 2 □ Cramation 3	CARamoval from State	20b. Place ceme	of Disposition (A tery, crematory of	r other pla	ice)	Data	20c. Location	- City or T	own, Stete	
Pag mant ant: ury o	4 Donation 5 Other (Spec	ify)	Hyndm	an Cemet	ery		10-4-20	00 Hu	ndmar	. PA	
permit. Pag Department Important: I any injury o	21. Signature of Funeral Service Lic	17.1	7,00	Hanv	011 H	ess of Facility • Zeigler	. Funera	l Home			
	23a. Pert1. Enter the disease or co shock, or haart failure. Uist on	mplications that award	the death D	Hynd	man di	PA 155	45 or respiratory	arrast.	- T	Approxima	ate
Dhysisian	shock, or haart failure. List on	y one causa or each lin	е.						- 1	Approxima Interval Ba Onset and	tween Death
Physician /Medical	Immediate Causa (Final	1.00				1					40
Examiner	diseasa or condition rasulting in daath)	. ADENOC			1	LUNG	_		-	DINE	智人.
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n and iai-transit		b	Due to for se	a consequenca o	M.				1		
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ficete be executed physician and ss the burial-transit edical Examin	Causa (Disaasa or injury that initiated events	c	Due to (or as	a consequenca o	f)·						
	resulting in death) Lasf		700 10 (01 us	a 00/150400/102/0	.,.						
death certifie attending of for use estimated		d									
d for	Part II. Other significant conditions	contributing to death bu	t not resulting	n in the underlyin	n causa di	iven in Part I.	23b. Dic	d tobacco use co	ontribute	to the cause	of death
that the death certified by the attending dateched for use e		commoding to count bu		y III tito olioonyiii	g			Yes 25No		obably 4	
£ 00 >											
been should								s an autopsy formed?	a	Vare eutopsy vailabla prior ompletion of f death?	rto
0 - 5 -							1	Yes 2 No	1	☐ Yas 2[≥ No
certificate rector, pag	25 Was case referred to medical					28 Place of De	ath (Check only				
	axaminar?	Hospital: 1 ☐ Inpatie	nt 2 TER/	Outpatient 3	DOA OI	hor		sidenca 6 🗆 Ot	her /Spec	ify)	
er this neral d		28a. Data of Injur (Month, Day	v 28t	o. Time of Injury	28c. Inju		T	how Injury occu		,	
Attending of death. ector: After by the funeral of	1 Natural 5 Pending 2 Accident investigati			М		Yes 2□No	9-11				
72 = c T	3 Suicide 6 Could not defermine		ry - At home, . (Specify)	, farm, sfreef, fact	ory, offica		28f. Location City or To	(Street and Num own, State)	ber or Ru	ral Route Nu	m <i>ber</i> ,
To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by Medical Certiff	29a. Certifier Certifying F	Physician: To the best of aminar: On the basis of and manner sta	examination								(s)
ithin of the omple	29b. Signature and title of certifier	A 4			29c. Licen	se number		29d. Date sign	ed (Month	, Day, Year)	
	11/	111		1	D	1/10/		OCT.	1	2000	2
m	10 pustra	10 y /d	anne	a) Cura Stati	リー	14865 aberland, Hospital		901,	1	2000	,
10	30. Name and address of person wh			a) (Type, Print)	Cun	berland,	MD 2	1502			
01-1	KOBUSTIANO - 31. Date filed (Month, Day, Year)	J. BARRES	r's Signature	- Memo	rial	Hospital	Medica	l Buildi	ng		
State Registrar		2000 1/2		6	1						



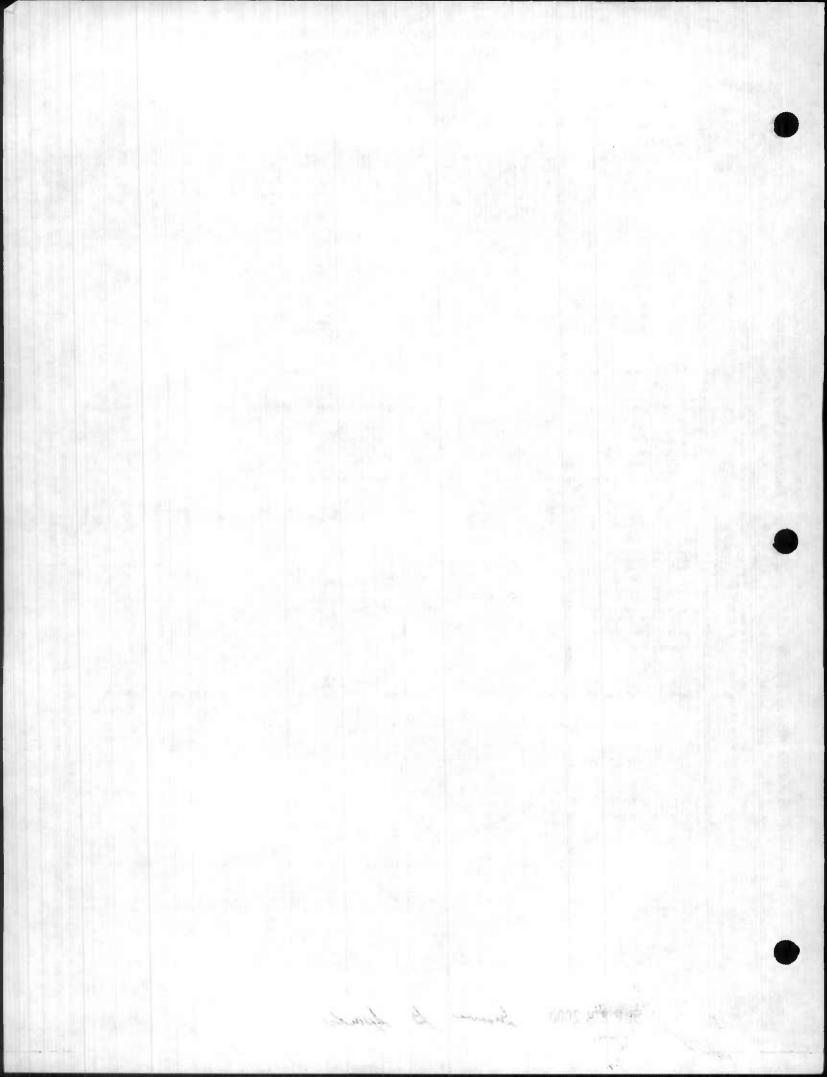
State of Marylan

d / Department of Health and Me		3246
Certificate of Death	Reg. No.	0 2 4 0

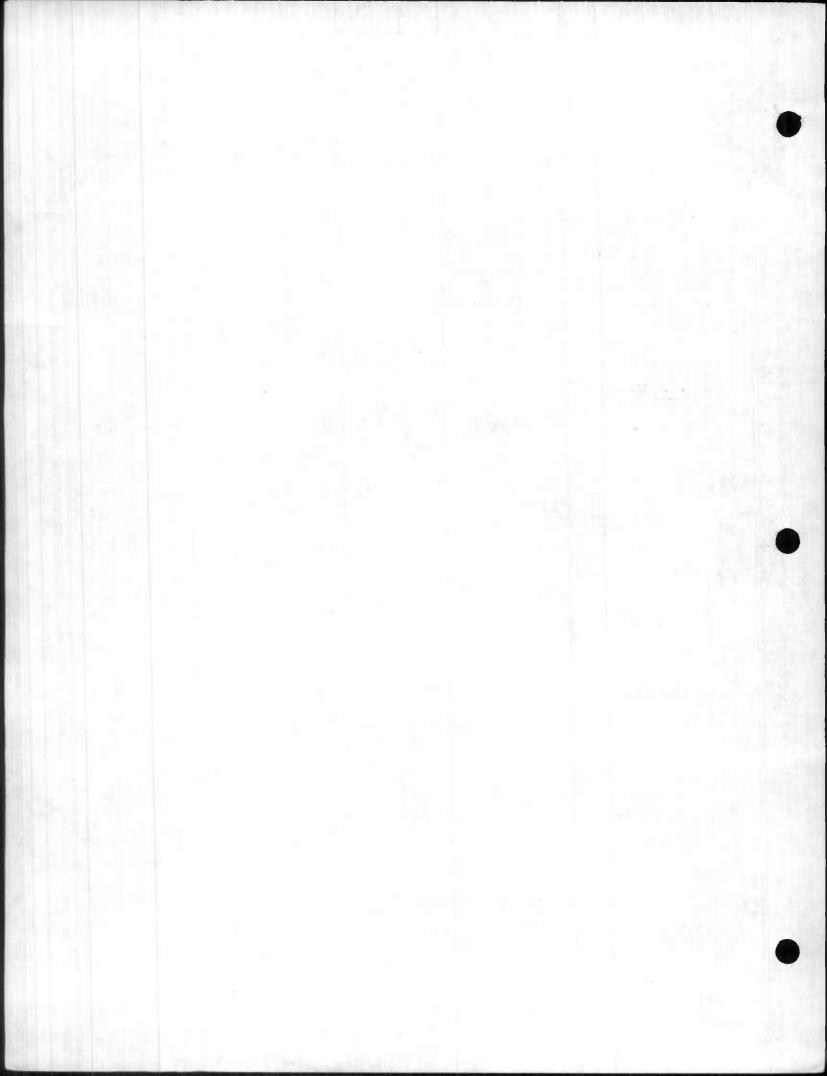
			C	ertificate of	Death	Reg. N	lo.	02404			
		Decedent's Neme (First, Middle, Last)				ete of Death	ey Yeer	3. Time of Death			
10	Physiciai /Medica	LUIS ILAN SILKIVER	PLATT				25 200				
	Examine	An English blome //f not institution give street and give	ber)		4b. City, Town, or Locatio	n of Death 4	c. County of De	ath			
		Memorial Hospital & Medic	al Center	1	Cumberland	A	11egany				
	Funeral Director	5. Sociel Security Number 6. Sex 1 M 2 F 57 Yrs. 6. Sex 1 Months Deys Hours Min. 7. Age (In yrs. lest birthday) H Under 1 Year Months Deys Hours Min. 6. Sex (Month, Day, Year) OCT 6 , 1 9 4 2 MA									
	pu s	Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or	r Location				10d. Inside City Limits			
	the Marylar 28s-f show northed at		CUMBER				1 ☐ Yas 2 ☐ No				
	vith the Mar	10e. Street and Number		10f. Zip Code		10g. C	Country?				
	th with the Maryla 23s or 28s-f sho	FURNACE STREET EXTN.		2150	12		U.S.A.				
	r Reme 23 diner must	11. Meritel Stetus 12. Wes Deced	lent Ever in U,S. 1	13. Was Decedent of I	Hispenic Origin? (Specify en, Mexican, Puerto Ricar	Yes or No-		nerican Indien,			
5-0020	urs a	3 ☐ Widowed 4 ☒ Divorced If Yes, Give	No No	1 ☐ Yes 2 ☑ No		i, etc.)	Bleck, Wh	WHITE			
5-0	be filed within 72 hours tal Hygiene. d other then "netural", overft, or a find or Elec-	15. Decedent's Education (Specify only highest grade completed)	16a. De	ecedent's Usuel Occup	pation during most of working	16b.	Kind of Busines	s/industry			
2	A 1 A 1	Elementery/Secondary (0-12) College (1-	40r 5+)		during most of working d)		To a m				
121	Hygien ther ti	12 17. Fether's Name (First, Middle, Last)	H	OMEMAKER	18. Mother's Name (Fire		HOME				
Maryland	lid be flental his double for every				HAZEL RU						
Z	should be nd Mental marked o	19a. Informant's Neme/Reletionship (Type, Print)	19h M	laiting Address (Street	t end Number or Rural Ro			Zin Code)			
Ma	and 2 sauth ar n 27 is or trau	KIMBERLY LONG / DAUGHTER			LODGE ROAD						
re,	Hear tem	20a. Method of Disposition	20b. Plece of Di	isposition (Name of cremetory or other ple	De		Location - City of				
altimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, trailing once.	1	AVALE,	MARYLAND							
Ba	permit. Departr Importu	Mandy A Locheuce UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502									
	100	23a. Pert1. Enter the disease, or complications that ca shock, or heart tailure. List only one ceuse on ee	used the deeth. Do not ch line.	enter the mode of dyi		Approximete Intervel Between Onset end Deeth					
)	Physician /Medical	Immediate Cause (Finel) Onset end Deeth							
	Examiner		ic Shock	4				2 days			
			Due to (or as e con	nsequenca ot):							
	ficate be executed s physician and s the burial-transit	b. Urosepsis Due to (or es e consequenca ot):									
ć	be executed ician and burial-transit	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated evenits									
68760,	physicial the burner	Ceuse (Diseese or injury that initiated events	Due to (or es e con:	sequence of):							
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Вох	attendin	d									
	d by the attendidates	Pert II. Other significant conditions contributing to dea	th but not resulting In th	e underlying ceuse gi	ven in Part I.	23b. Did tobacc	co use contribu	ta to the cause of death?			
P.0	and the de detached detached	Diabetic Ketoscidosis	_ Diabetic Ketoacidosis, Coronary Artery Disease,								
JS,	signed be de		Solonary Al	tery Disea	-		244	Mara nutana diadina			
Vital Records,	The law require cate has been si page 2 should I	Acute Conjestive Heart F	ailure, Upp	er Gastroi		24e. Wes en eut performed?		Were eutopsy tindings available prior to completion of ceuse			
3ec	has b			40 - 11-11-1				of deeth?			
a E	cate ha					1 Yes	2/0 No	1 Yes 2 No			
Vit	Physician: The this certificate ral director, par	25. Wes case reterred to medical examiner? Hospitel:		Ott	26. Piece of Death (Ch						
of	the signature of the si	10 165 2,52 NO 102 In	patient 2 ER/Outpa	TIENT 3LI DOA	4 Li Nursing Home	5 Residenca Describe how in		pecify)			
on	ding th. After fune	27. Menner of Death 1 Solution Solution 28e. Dete of (Month) 2 Accident 1 Solution 28e. Dete of (Month)	, Dey Year) Injui	ry Wo	rk?]Yes 2□No		,,				
Division	or Attending after death. Director: After in by the fune	3 Suicide 6 Could not be determined 28e. Place of	of Injury - At home, tarm,	, street, fectory, office	28t. I	Location (Street end Number or Rurel Route Number,					
á	- PEC 1	building, etc. (Specify) City or Town, Stete)									
	Hospi 4 hours Funer taly fill	29e. Certifier (Check only one) 29 Medical Examiner: On the base and menner	is of examinetion end/or	eeth occurred et the ti r investigation, in my	me, dete end pleca, end copinion, deeth occurred et	lue to the ceuse(the time, date e	(s) end menner nd placa, end d	es steted. ue to the ceuse(s)			
	within 2 To the comple	29b. Signeture and title of pertifier		29c. Licens	se number	29d. D	ate signed (Mo	nth, Dey, Year)			
	5	Make true (). 1	turn	000	14865	SEP	TEMBER 2	5, 2000			
		30. Name and address of person who completed cause	of death (from 23e) (Tvi		_ 1000	DHI		, 2000			
	nas	ROBUSTIANO J. BARRERA, ME			, 500 MEMORI	AL AVE.	, CUMBE	RLAND, MD			
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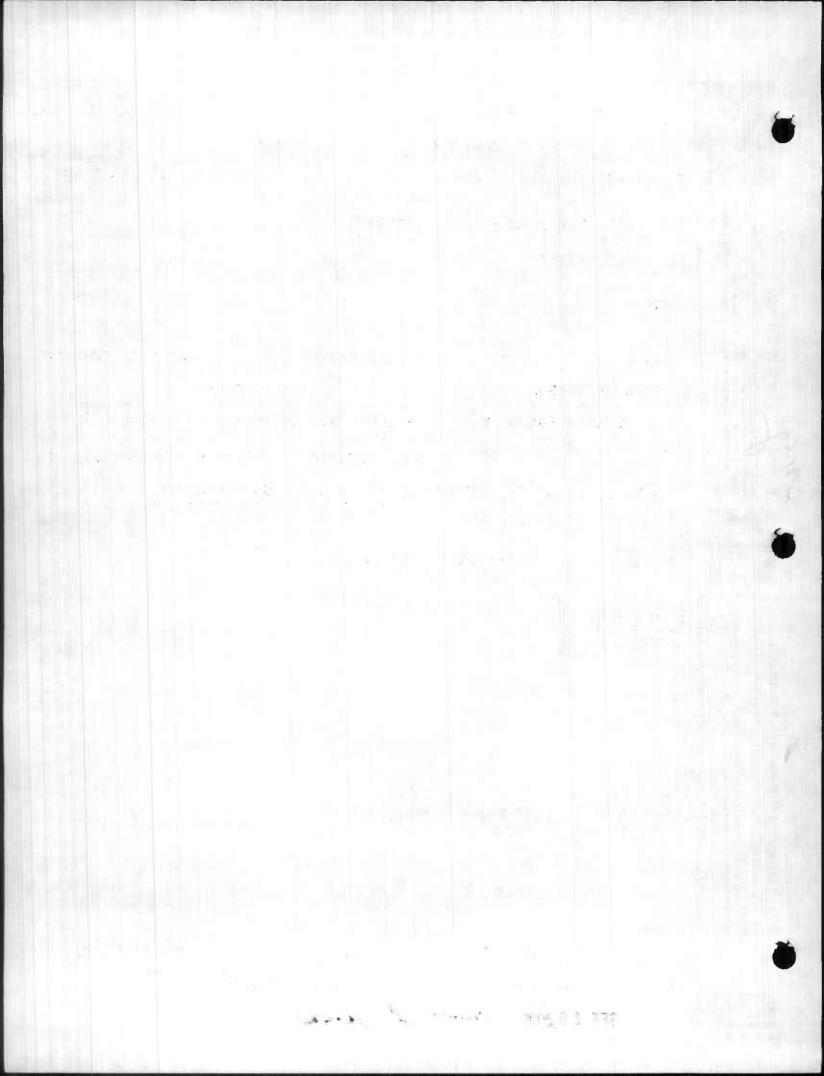


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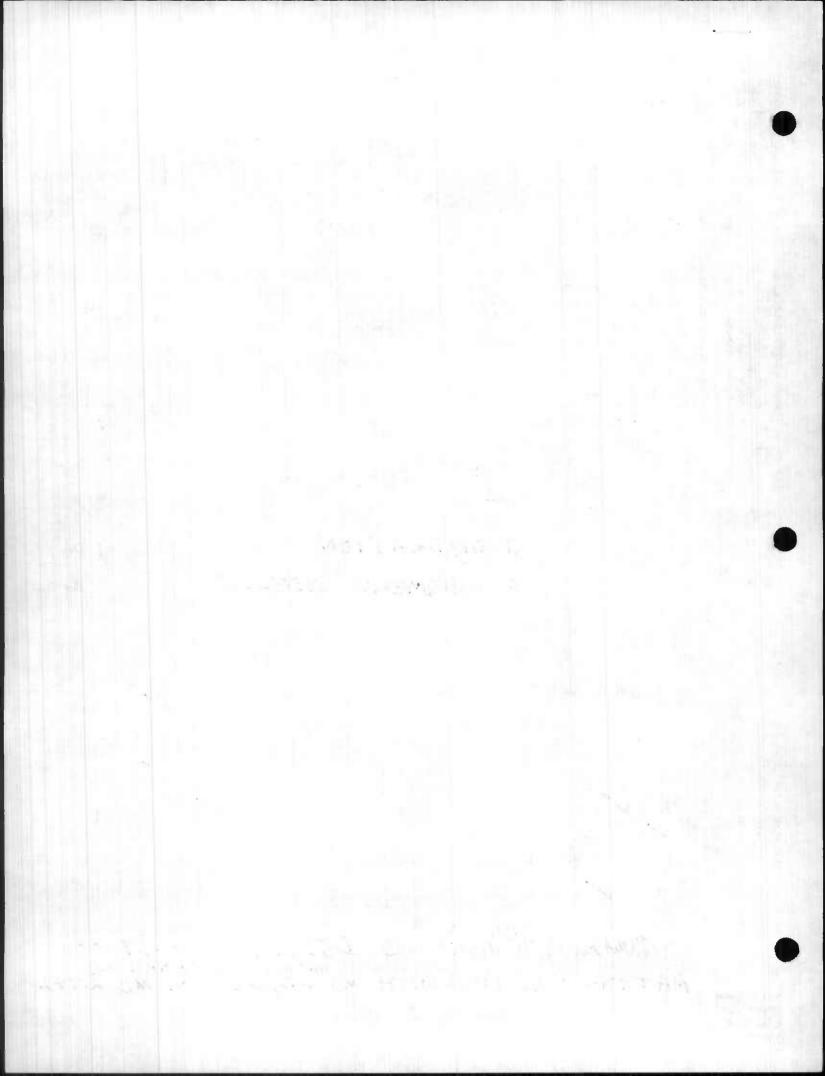


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

PENAL BOUTE PICKETT SEND SOUTH PICKETT SEND	Tel9:				Otate of Ivia			ificate				Reg. No.	U .	32466	
EXAMPLE PLOKES FOR THE FAMILY PROPERTY AND ALL PROPERTY	Division 1		1. Decedent's Name	(First, Middle, La	st)								Year	3. Time of Death	
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Director 10	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24						If Under 24 Hrs.	8. Date of Bir					
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	Physic /Medi		1. Decedent's Neme (First, Middle, Las	Rudy					Septem	ptember 27 2000		3. Time of Death 3:00 am	
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020	or its	by Funeral	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 □ Yas 2 X If Yes, Give Yeer or Detes:	?			of Hispanic Orig Cuban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	14. Rac Blee Specify	ck, White,	nerican Indian, hite, etc.	
21215-0020	within iene. Than	Completed	15. Decedent's Edi (Specify only highest gred Elementery/Secondery (0-12)	ducation ede completed) College (1-4or 5+)		16a. Decedent's Usual Occ (Give kind of work dor life. DO NOT use ret		one during most stired)	of working	16b. Kind of Business/li			
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month Dav Yaar **Physician** 12:10 pm Edwin Joseph Rice 2000 October /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Nama (If not institution, give street and number Examiner Cumberland
If Undar 24 Hrs. 8. Dat
Hours Min. (Mo Devlin Manor Nursing Home Allegany If Under 1 Yaar Birthplaca (Stata or Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) 5. Social Security Number 8. Data of Birth (Month, Day, Year) **Funeral** XOM 2DF Months Days Maryland **Director** 219-07-4492 Sept. 4, 1919 Usual Rasidance of Deceder Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental Hyglane. and of Health and Mental Hyglane. and if item 27 is marked other than "neturel", or items 23s or 28s-f show and if item 27 is marked other than "neturel", or other traumatic event, the Modical Exertine must be notified at uny or other traumatic event, the Modical Exertine must be notified at 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits other than "natural", or frame 23s or 28s-f show went, the Medical Examiner must be notified at X□ Yes 2□ No Director Allegany Cumberland Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? **USA** 455 Walnut Street 21502 Funeral 12. Was Decedent Evar in U,S. Armed Forcas? X□Yes 2□No If Yas, Giva 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 1 Nevar Married X Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 🎽 No Specify: Specify: þ 3 ☐ Widowad 4 ☐ Divorced White Yaar or Dates 1942-45 Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grade complated) Elementery/Secondery (0-12) College (1-4or 5+) Telephone Co. Supervisor 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) Be Maude E. (Kauffman) Joseph Augutus Rice 2 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 455 Walnut Street, Cumberland, MD 21502 Hilda Rice 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata X□ Burlal 2 □ Cramation 3 □ Ramoval from State permit. Page Department of Important: If any Injury or once. St. Lukes Lutheran Cem. Cumberland, MD 21502 10/4/00 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 21. Signature of Funeral Service Licent Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502 23a. Part1. Entar the diseasa, or complications that shock, or heart failura. List only one cause on daath. Do not antar tha mode of dying, such es cerdiac or raspiratory arrest, Approximete Intervel Between Onset and Death **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in death) **Examiner** Due to (or auta consequence of): Examiner materi physician and s the burial-transit requires that the death certificate be executed Sequantially list conditions, if any, laading to immediata cause. Enter Underlying Causa (Disaasa or injury that Initiated events rasulting In daath) Last Due to (or as a consequence of): P.O. Box 68760, Ce-Physician/Medicai Due to (or as a consaquance of): attending pl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wara autopsy findings availabla prior to complation of causa of death? Completed 24a. Was an autopsy s cartificata has t 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: aftar death. Director: After this cartifice funeral director, 25. Was cese referred to medical Be 26. Placa of Death (Check only ona) Othar:

A☐ Nursing Homa 5☐ Rasidance 6☐ Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA Certification: To 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Mennar of Death 28b. Tima of 28d. Describe how Injury occurred **T**□Natural 5 Panding 1 ☐ Yes 2 ☐ No invastigation 2 Accident 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) à 4 Homicide C e Hospital or 24 hours aft Funeral Di 29a. Cartifiar 1 Cartifying Physician: To tha best of my knowledge, daath occurred at the tima, data and placa, end due to the ceusa(s) and mennar as stated. Medical To the Hosp within 24 hor To the Fune completaly fi (Check only one) 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29d, Data signed (Month, Dav. Year) 29b. Signatura and titla of certifiar 29c. Licensa number Cot. 2200 D D0017561 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) Mis 6=U212 12 2158L Bellinenn 912 NITI 32 Registrar's Signatura 31. Data filed (Month, Day, Yaar) OCT 0 4 2000 State Registrar

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 32469 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Edna Elizabeth September 29 2000 7:40pm /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Reeders Memorial Home Boonsboro Washington If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Aug. 7, 1914 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 2⊠ F Yrs. 216-22-9247 86 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Tyes 2 No Maryland Washington Hagerstown Directo 10e, Street and Number 10f. Zip Code 10a. Citizen of Whet Counfry? 17527 Virginia Avenue 21740 U.S.A. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Maritel Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baltlmore, Maryland 21215-0020 1 Yes 2 No Specify: white Specify: by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 0-6 College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Physien Important: if tem 27 ie marked other that eny Injury or other treumatic avent, first page. homemaker her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John E. Dick Sarah Rowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Wanda Head Daughter-In-17527 Virginia Avenue, Hagerstown, Maryland 21740 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Oct. Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3,2000 Hagerstown, Maryland 21. Signature of Funeral Service Licensee Minnich Funeral Home 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 2174D 23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) one week Examiner Examiner mong one week that the death certificate be asscuted and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical 40 Due to (or as a consequence of): for use as Unteroun, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably Unknown makelise melle fue Records, þ The law requires 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 : 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2NNo Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describa how injury occurred 28b. Time of 28c. Injury at Work? After or Attending 1 Netural 2 Accident 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funerel Director: Afte completaly filled in by the fun. 1 Yes 2 No Investigetion 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. Medical 29a, Certifier (Check only 29d. Dafe signed (Month, Day, Year) 29b. Signature and the of certified 29c. License number

State Registrar

DHMH 16 Rev 6/95

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Boonsbaro ma 21713

301-4328470

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

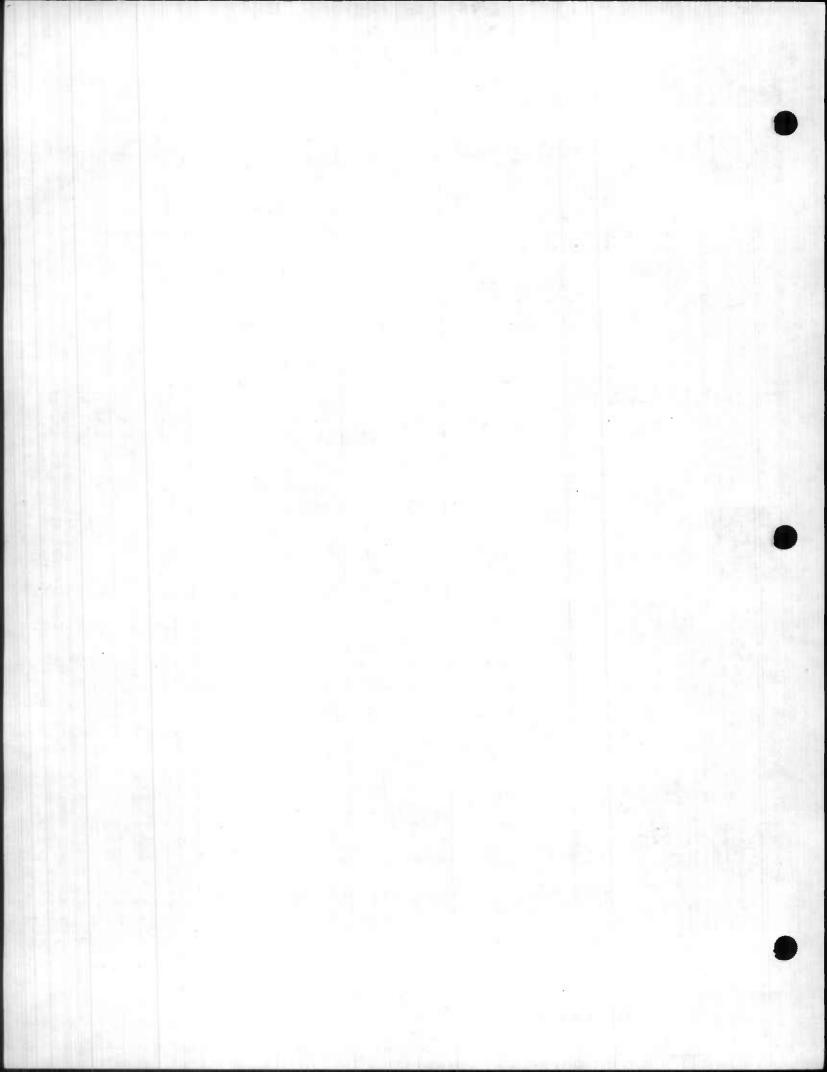
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31. Date filed (Month, Day, Year)

OCT 0 3 2000

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203 Lappans
32. Registrar's Signature /



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		State of Maryland / Department of Health and Certificate of Death	Re	eg. No. 00	324.70					
	Physiciar /Medica	CHARLES CRABLE SHRYOCK	2. Date of Deet Month Sept. 3	3. Time of Death 10:30 a.m.						
	Examine		BERLAND	4c. County of D						
Ì	Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min.		Year) 9.	Birthplace (State or Foreign Country) MD					
	show start	10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits					
	Se-fel	MD Allegany Cumberland		345.3	Yes 2 No					
	deeth with the Meryland ms 23a or 28a-f show finant or notified at	10e. Street and Number 10f. Zip Code	10	0g. Citizen of What	Country?					
	r forms 23s	5 1114 Kentucky Avenue 21502 11. Marital Status 12. Wes Decedent Ever in U.S. 13. Wes Decedent of Hispanic Origin? (S	pecify Yes or No-	USA 14. Race - A	merican Indien,					
5-0020	urs after	3 ☐ Widowed 4 ☐ Divorced Yeer or Detes:	o Rican, etc.)		/hite, etc.					
5-0		15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	rking	16b. Kind of Busine						
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	2 should be filed within on and Mentel Hygiene. Is marked other than raumatic event, the Market To Re Comm		ne (First, Middle, M		- <u>y</u>					
yiar	end Mentel marked o muratic eve	William C. Shryock Lorena	(Tw	igg)						
Maryland	d 2 sho th end 7 le m traum	19e. Informant's Name/Reletionship (Type, Print) Nellie E. Shryock 1114 Kentucky Avenu								
Baltimore,	permit. Pages 1 end 2 should be filed within 72 h. Depertment of Health end Mentel Hygiene. Important: if item 27 ie marked other than "natuminy Injury or other traumatic event, pre Medical MRS. To Re Commission	With Deliver of Disposition 1 Special 2 Cremetion 3 Removel from State 20b. Piece of Disposition (Name of cemetery, crematory or other place)		20c. Location - City						
Itim	permit. Page Depertment of Important: if any Injury or once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral	2000 F	lintsto	ne, MD					
Ba	Depenti Depenti Importu any Inj	Cumberland, Mary	yland 2	21502						
	Obveriales	23a. Part1. Enter the disease, or comblications that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only shock ause on each line.	or respiratory arre	est,	Approximate Interval Between Onset end Deeth					
	Physician /Medical	Immediate Ceuse (Final		21						
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Vital	Physician: The this certificate rel director, parel Co.; To Be Co.;	Hospital:	ath (Check only one	ө)						
of	ty this is	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing H	lome 5 Reside 28d. Describe ho	nce 8 Other (5	Specify)					
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	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place (Check only one)								
	within To the compi	29b. Signeture and title of certifier 29c. License number	29	9d. Date signed (M	onth, Day, Year)					
	(Centry Palling In N D17565	×	act 2	2000					
	C,	Alleholly Bollino M.D. 322 Nacional Highway	LaVale	MD 2150	2					
	State Registrar	31. Dete filed (Month, Dev. Year) 2000 32. Registrer's Signeture & Sparks								

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ral	5. Social Security !	Number	6. Sex	7. Aga (In yr.	s. last birthday)	If Under	Year	If Under	24 Hrs.	B. Date of Bir			olace (State	or Foreign
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	19a. Informant's N	Spyde:	hip (Type, Print)		P.O. Maili	ng Address	Street	and Number	or or Rurel	Route Numb	er, City or Tov	vn, Stete, Zip	Code)	
	wife 20a. Method of Dis	_	des .	l and				, reing	O_C					
	20a. Method of Dis	sposition Cremation	3 Removal fro		Place of Dispo cemetery, crea	matory or of	e or ner pled	ce)	10) / 04	20c. Locatio	ocation - City or Town, Stata		
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	21. Signature of F	uneral Service L	Licensee								e, P.A	A.		
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icia icia	Part II. Other signi	ificant condition	ns contributing to	deeth but not re	sulting in the u	indertving ce	usė giv	en in Part I		23b. Dld	tobacco use	contribute t	o the cause	of death?
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by P														
2										24a. Was	an autopsy ormed?	24b. W	ere autops	findings to
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E										10	Yes 2 No	11	☐ Yes 2	□ No
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e e	25. Was case refe examiner? 1 Yes 2	(No		te of Injury	28b. Time o	1 28	c. Injur Wor	y et rk?	2	8d. Describe	how injury oc	curred		
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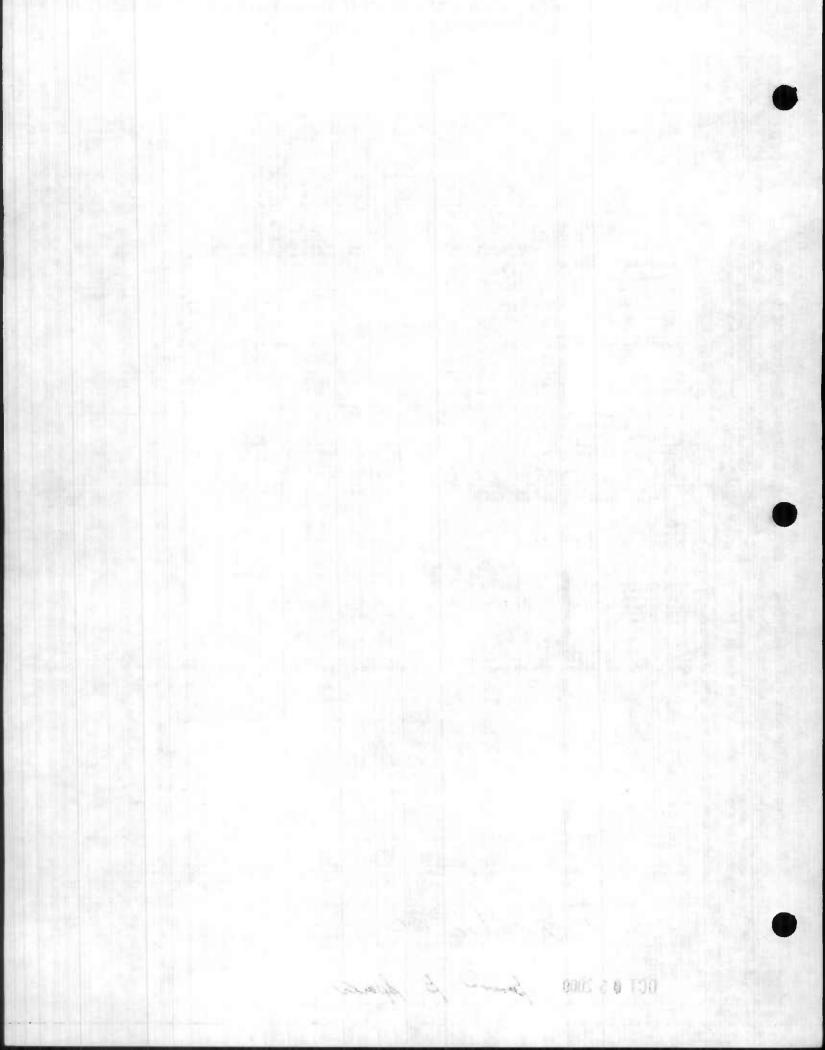
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State of Maryland / Department of Health and Mental Hygiene 00 32472

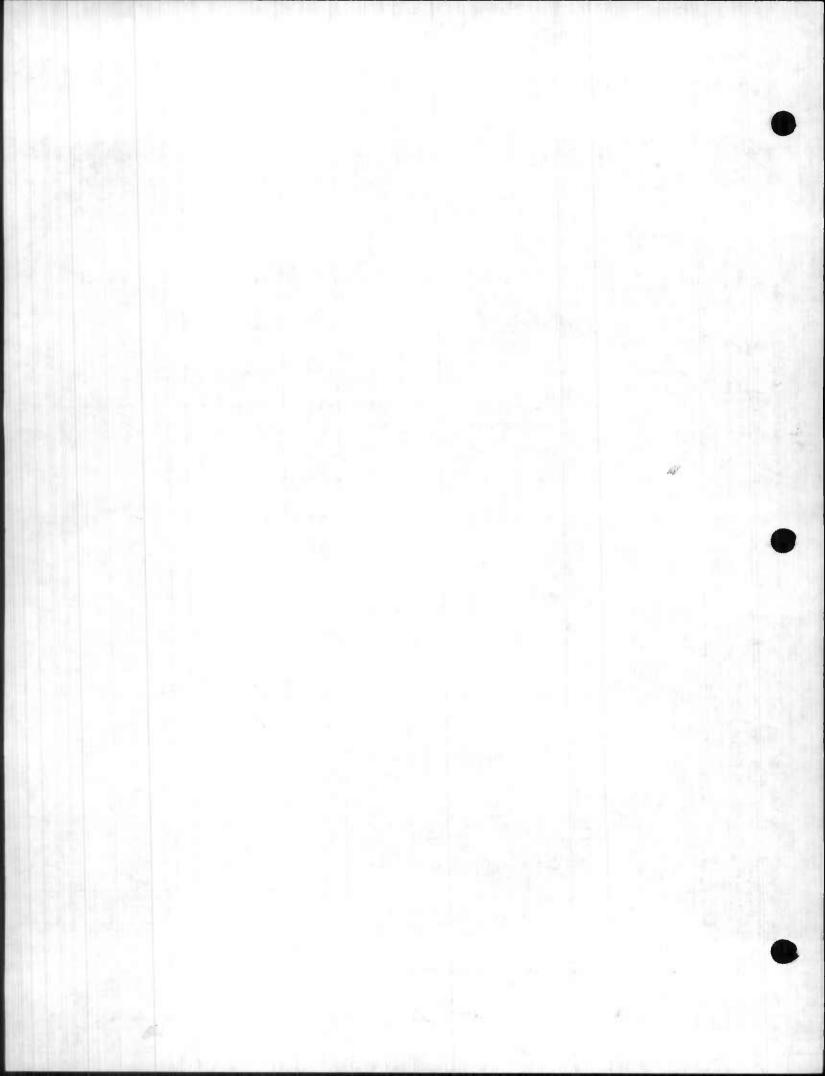
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Physician /Medical	1. Decedent's Nama (First, Middle, L Marjorie	ast) Lee	Shafi	er			2. Deta Monti 10		Yeer 2000	3. Time of Death 7:20 am
Examiner	4a Facility Name (If not institution, g Memorial Hospit		Center		4		m, or Location of		egany	
Funeral Director	212-18-1910	Sex 7. Age (1	In <i>yrs. last birthd</i> ey 80 Yrs.	Month:	ar 1 Year Deys	If Under 24 Hours	4 Hrs. 8. Dete de Min. Jul	Birth Year)	9. Birthp	eleca (Stete or Foreign MD
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ad within 72 hou ygiene. werthen 'natura k, the Medical E.	15. Decedent's (Specify only highest g	Education	16a. Dece (Giv. life.	DO NOT		ition u <i>ring m</i> ost o	of working		f Business/Ind	
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requires t sen sign hould be							24e.	Wes en eutopsy performad?	ev	era eutopsy findings eilable prior to mpletion of cause death?
The law sate hes b page 2 s								1□Yas 2⊠N	0 1[Yes 2□ No
certificate rector, pag	25. Wes case rafarred to medical examiner?	112-1			100		of Death (Check	only one)		
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tal or Attendi rs after death. al Director: A led in by the f		determined 268, Place of Injury - At homa, tarm, Streat, tactory, office						tion (Street end Nu or Town, Stata)	imper or Hurs	ar Mouta Number,
To the Hospital or Attend within 24 hours after deet To the Funeral Director: completely filled in by the		hyeician: To the best of a miner: On the basis of ax end menner steted	amination end/or in							
Withir Comp	29b. Signatura and title of certifiar	1 1	,	2	9c. License	number		29d. Date sig	gned (Month,	Dey, Year)
6	30. Name and addrass of person who	Menhel cause of deat	h (Item 23a) (Type		D5494	6		ОСТОВ	ER 4,	2000
nus	DR BOYD SPRENKLE	600 MEMOR			400	CIME	ERLAND, M	D 21502		
State	31. Data filed (Month, Dey, Year)	82. Registrar's		10-	1	COLID		2,502		

DHMH 16 Rev 6/95

MARJORIE SHAFFER 212-18-1910



inian	1. Decedent's Name (First, Middle, Las	st)				2. Date of De		3. Time of Deeth	
sician	Garnett R Sa	Month	+ 3	Year 2000 06:47	,				
edical miner	4e Facility Neme (If not institution, give				4b. City, Town	n, or Location of Deat	1		
	Veteran's Hospi	tal - Balt	more		Balt	imore			
ral	5. Social Security Number 6. Se	ex 7. Age (i	In yrs. last birth	Months D	ear If Under 24	Hrs. 8. Dete of Bir Min. (Month, Da	th sy, Year)	Birthplace (State or Forei Country)	gn
or	579-48-9843	AM ZUF	68 Y	rs.		May 3, 3		Virginia	
	Usuel Residence of Decedent 10e. State 10b. County	1	0c. City, Town	or Location				10d. Inside City Limi	ts
ò	Maryland Wicomico		Salisbur	y				1 □ Yes 2 □ N	No
recto	10e. Street and Number	7.00		10f. Zip Co	de		10g. Citizen of V	What Country?	
II D	1021 Cecil Street			218	304	18	USA		
Funeral	11, Maritel Stetus	12. Wes Decedent Eve Armed Forces?	er in U,S.	13. Was Decedent	of Hispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Rac	e - American Indian, ck, White, etc.	
200	1 Never Married 2 Married	1 Yes 2 No	Korea		No Specify:	delice rinder, order,	Specify		
d by	3 □ Widowed 4 ☑ Divorced	Yeer or Dates: A	r Force						
Completed	15. Decedent's Ed (Specify only highest grad		(4	lecedent's Usual O Give kind of work d life. DO NOT use n	one during most o	of working	16b. Kind of Bu	usiness/Industry	
dusc	Elementery/Secondary (0-12)	College (1-4or 5+)		to Mechanic			Sears R	oebuck & Co.	
Be Co	17. Father's Neme (First, Middle, Last)					s Name (First, Middle			
To B	Garnett Reese Sautter	r. Sr.			Mary I	llian Whitma	an		
-	19a. Informent's Name/Relationship (7		19b. I	Mailing Address (Si		or Rural Route Numb		State, Zip Code)	
	Bryan A. Sautter /Sor	n		Barnsdale			ry, Md 21804		
	20a. Method of Disposition 1₺ Burial 2 ☐ Cremation 3 ☐	Removel from State	cametery,	Disposition (Name of crematory or other	r place)	Date	20c. Location -	City or Town, Stete	
	4 □ Donation 5 □ Other (Specify		Maryland	Veterans C	iem.	8/9/2000	Hurlock	, Md	
	21. Signature of Funeral Service Licens	See		22. Name end A	ddress of Fecility	Holloway Fu	meral Hom	e Professional MD 21804	
	David H. Thompson	n per DVR		ASSOCIATIO	n DUL Snow	7 Hill Road S	salisbury,	MD 21804	
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du	e to (or as a co	5-011/			ilite.		
Physician/Medical	Cause (Disease or injury that initialed events resulting in death) Lest	c	e to (or es a co	nsequence of):					
sicia	Part II. Other significant conditions co	ontributing to death but r	not resulting in t	he underlying caus	e given in Pert I.	23b. Did	tobacco uae co	ntribute to the cause of dear	th?
by Phys						10	Yes 2□ No	3 Probably 4 Onkno	wn
Completed b						24a. Was peri	s an autopsy ormed?	24b. Were autopsy finding aveilable prior to completion of cause of death?	S
Mo						10	Yes 2 No	1 ☐ Yes 2 ☐ No	
Be	25. Was case referred to medical examiner?	/		7777		of Death (Check only	one)		
2	1 Yes 2 No	Hospital: 1 Inpatient				sing Home 5 Res	-		9
lon:	27. Manner of Deeth 1 Naturel 5 Pending	28e. Dete of injury (Month, Day Y	'ear) 28b. Tir Inj	me of ury M	Injury et Work? 1 Yes 2 N		how injury occur	Ted	
edical Certification:	2 Accident Investigation 3 Sulcide 6 Could not be determined		- At home, farm Specify)			28f. Location	(Street and Numb wn, State)	ber or Rural Route Number,	
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2	29b. Signeture end titls of confiller	end manner states	J	290 1	cense number		29d Date signe	d (Month, Day, Year)	
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M	1	MAG			1 6/6/		AVELST 3, 2000		
	2	MD	+ (h	P1	2996		AUgust	3,2000	
	30. Name and address of person who o	completed cause of deal		ype, Print) reene 57	2996 - 10 A	Himore, M	10 21	3,2000 202	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth Month 09 2000 0400 Mildred Alexa Sherer 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Genesis Eldercare - Spa Creek Center If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 10/13/06 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 1□ M 2∰ F 315 34 4398 Indiana Usuel Residence of Decedent 10e, Stete 10b Count 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Annapolis 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 21401 1877 Severn Grove Road 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Giva Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, atc. 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Legal Industry Attorney 17. Fathar's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Edna Peggs Richard Gallagher 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1877 Severn Grove Road, Annapolis MD 21401 Maureen Sherer/daughter 20b. Place of Disposition (Neme of 20c. Location - City or Town, Steta 20e. Method of Disposition 9/20/00 1 ☐ Burial 2 X Cremation 3 ☐ Ramoval from Stata Metropolitan Crematory Alexandria VA 4 Donetion 5 Other (Specify) 21. Signature of Funerel Service Licensee 22 Name end Address of Facility Advent Funeral & Cremation Services agon Annapolis MD 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the moda of dylng, such as cardiac or respiretory arrast, shock, or heert failure. List only one cause off each line. Approximata Intervel Between Onset and Deeth Acute My occardial interction Immediate Ceuse (Final disease or condition resulting in death) da Due to (or es a consequence of): Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobacco usa contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 25 No 24b. Were eutopsy findings availabla prior to complation of ceusa of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Director

than "natural", or items 23s or the Medical Examiner must be r

7 is marked other traumatic event, t

important of Health an Important if hen 27 is n vny injury or offer

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.

physicien and s the buriel-transit 65 esn O signed by the e is certificate hes director, page 2 after deeth.

Director: After this certifications

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Examiner Physician/Medical by Completed Be To

Certification:

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To the Hospital or A within 24 hours aftar To the Funeral Direc completely filled in b

25. Was cese referred to medicel exeminer? 1 Yes PANO

27. Manner of Deeth 1 Reture! 5 Pending Investigation 2 ☐ Accident 6 Could not be 3 ☐ Suicide 4 Homicide

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

Other: 4 Dursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work?

1 Yes 2 No

28d. Describe how injury occurred 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

26. Plece of Death (Check only ona)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and turn of pertifier

29c. License number 032036

29d. Dete signed (Month, Dey, Year)

30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print) 108 Di Danto Orine Cherta, mo 21619 Jourse

31. Dete filed (Month, Dey,

32. Registrar's Signeture

Registrar

Medical

29a. Certifier (Check only one)

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death Month Yaar Leonard John Schreiber Sr. OCT 03 2000 1710 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death The Memorial Hospital Easton Talbot If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 6 Sax 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Days Hours 110 M 2□ F Months Yrs. 221-24-8828 April 1,1926 Mary land 74 Usual Rasidenca of Decedent 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 X No Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21639 27391 Whitleysburg Road 12. Was Deceden! Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian Black, Whita, atc 1 Navar Marriad 2 Married 1 ☐ Yas 2 No Specify: Specify: white 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 9 farmer agriculture 18. Mothar's Nama (First, Middla, Maiden Surnama) 17. Fether's Name (First, Middle, Last) George Schreiber Pearl Webber 19a. Informani's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 27391 Whitleysburg Rd Greensboro, Maryland Anne Schreiber spouse 20b. Place of Disposition (Nama of cemetary, crematory or other place) Oct 7, 20c. Location - City or Town, Stata 20e. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Greensboro Cemetery 2000 Greensboro, Maryland 21. Signatura of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Fleegle - Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) 4W 0410 ever chronic obstructure formount duran years atrial tachy corde à hypoteusion 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an eutopsy

Physician /Medical Examiner Examiner

Physician/Medical

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/Medical

Examiner

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Funeral

Director

tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar mast be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than any injury or other trainment.

the Maryland

SCHREIBER, LEONARD Maryland 21215-0020

Baitimore,

Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disaasa or injury that initieted events rasulting in death) Lasl

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yas 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical axaminar? 26. Placa of Death (Chack only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Other (Specify) 1 Yas 2 No 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending invastigation Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datamined 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 T Homicide 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifiar

signed by the attending physician and d be detached for use as the burial-transit Box 68760. Division of Vital Records, P.O. peed has certificate After this or Attending F after death. filled in by To the Hospital o within 24 hours at To the Funeral D

3/00

29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and Iitla of certifiar

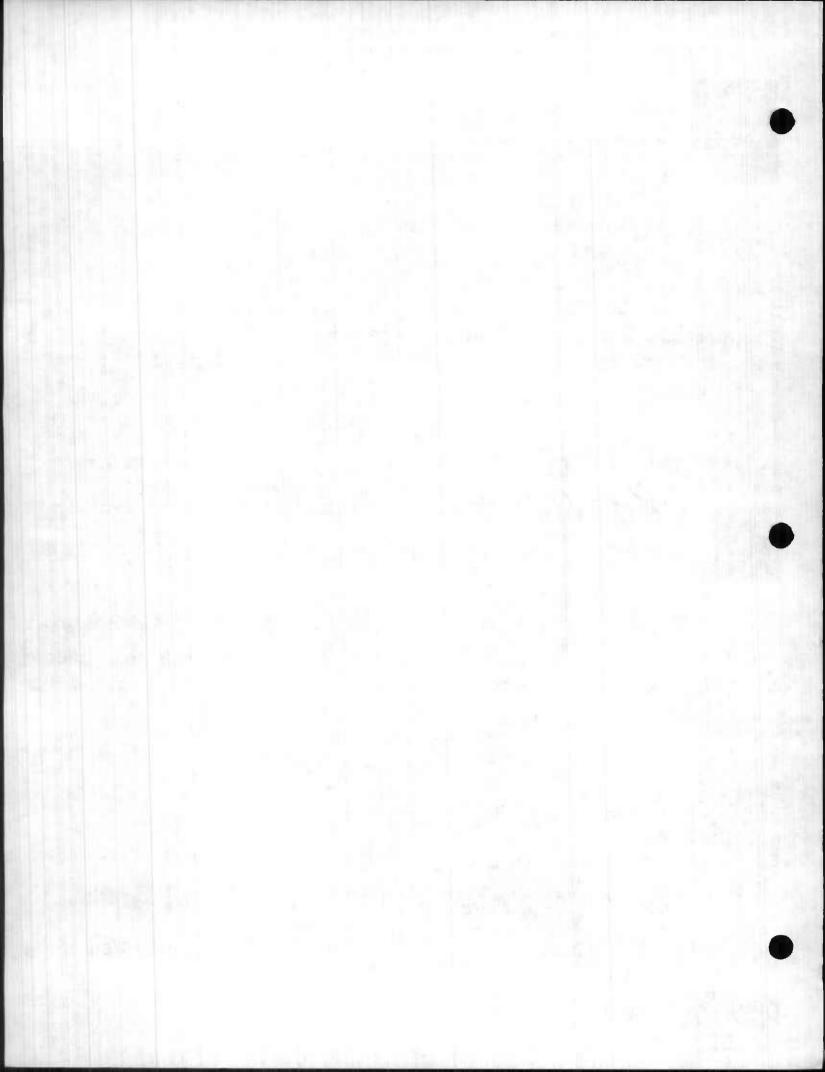
30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

506 Idlewild Ave Easton, Maryland Dr Syed Ali

State Registrar

31. Data filed (Month, Day, Year) 32. Ragistrar's Signature OCT 0 6 2000

D46020



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene 9/22/2000/#1 WCHD/MAP Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Fred H Tolbert **Physician** TOLBERT FRED September 19, 2000 8:03 a.m. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Hospita BAltimore Citu HOPKINS N/A JONS 6. Sex 1 0 M 2 □ F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min Yrs. 227-40-7954 66 1934 Virginia Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Director Accomack Virginia hincoteague 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4020 Main Street U. S. A. 238 23336 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dives 2 □ No If Yes, Give Year or Dates: 5 (4 - 5 %) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11 Marital Status Bleck, White, etc. traumatic event, the Medical Examiner permit. Peges 1 and 2 should be filed within 72 hours efter of Department of Heelth end Mental Hygiene. Important: If item 27 is marked other than "natural", or item 1 Never Married 2 Married Specity: White 1 Yes 2 No Specify. by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Tolbert (onp. ontractor Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Tolbert Mary Hopkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Ruth M. Tolbert 4020 Main Street, (hincoteague, Virginia 23336 Baltimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State any injury or one 1 Sunal 2 Cremetion 3 Removal from State Mechanics (emetery 9-23-00 (hincoteague, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Appliess of Facility Home 21. Signature of Funeral Service Licenses Baley (hincoteague, Virginia 23336 23a. Part. Enter the disease, or complications that caused the death. Do ot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Airway Obstruction 12 hours Examiner Due to (or as a consequence of) Physician/Medical Examiner Squamous Cell Carcinoma 6 months Metastatic The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Atrial Fibrillation Division of Vital Records, ð 24b. Were autopsy findings available prior to completion of cause of death? after death.

Director: After this certificate has been side in by the funeral director, page 2 should 24e. Was an autopsy Be Completed 1 Yes 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 27. Menner of Death 1 Neturel 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steled.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steled.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steled. 29a. Certifier complataly (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

JOHN J. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Typa, Print)

MO

32. Pegistrar's Signature

Friedewald

September 19, 2000

Johns Hopkins Hospital, 600 North Wolfe St, Baltimore, mo 21287

Personal Commence of the Service of Contractor Cartes and Contractor

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death TRIANTIS Month Year 8AM 1amer THEODORE 2006 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 1550 Andover Lane Frederick Frederick | H Under 1 Year | H Under 24 Hrs. | S. Date of Birth | Months | Days | Hours | Min. | Oct. 19, 1930 6. Sax 1 M 2 F 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign North Carolina 578-40-2737 69 Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Frederick Frederick 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1550 Andover Lane 21702 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Restaurant Equipment Elementary/Secondery (0-12) College (1-4or 5+) Mechanic 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Nich John Triantis Evangelina Biacou 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Paula K. Triantis (Wife) 1550 Andover Lane Frederick, Md. 21702 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Sept. 29, 20a. Method of Disposition 20c. Location - City or Town, Slete 1 Burial 2 Cremation 3 Removel from Brate Smithsburg Crematory Smithsburg, Md, Donation 5 Other (Specify) 2000 21. Signature of Runeral Service Licensee 22. Neme end Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 ennis 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth MYOCARDIAL ISCHEMIA Immediate Cause (Finel NOUVS diseese or condition resulting in deeth) ears metas Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequenca of) Due to (or es a consequence of): Pert It. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yea 2 No 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

the death certificate be execut Box 68760.

Records, P.O.

Division of Vital

Dispartment of Health and Important: If Item 27 Is in any Injury or other traum 2008.

Physician

/Medical

Examiner

Directo

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Completed

Be

Funeral

Director

'natural', or herrs 23a

Baltimore, Maryland 2121

Pages 1 and 2 should

Examiner physician and the bunal-transit Physician/Medicai 980 signed t þ Completed Be Certification: To

25. Wes case referred to medical examiner? 27. Menner of Death

5 Pending investigation

1 29 Neturel

2 Accident

4 | Homicide

(Check only one)

3 Suicide

29a. Certifier

6 Could not be determined

28a. Dete of Injury (Month, Day Year) 28b. Time of

28c. Injury et Work?

28e. Plece of Injury - At home, Ierm, street, fectory, office building, etc. (Specify)

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

1 - Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner steted.

29b. Signature and title of certifier HEGAZI, MD 29c. License number D44164

1 Yes 2 No

29d. Date signed (Month, Day, Year) 9-29-00

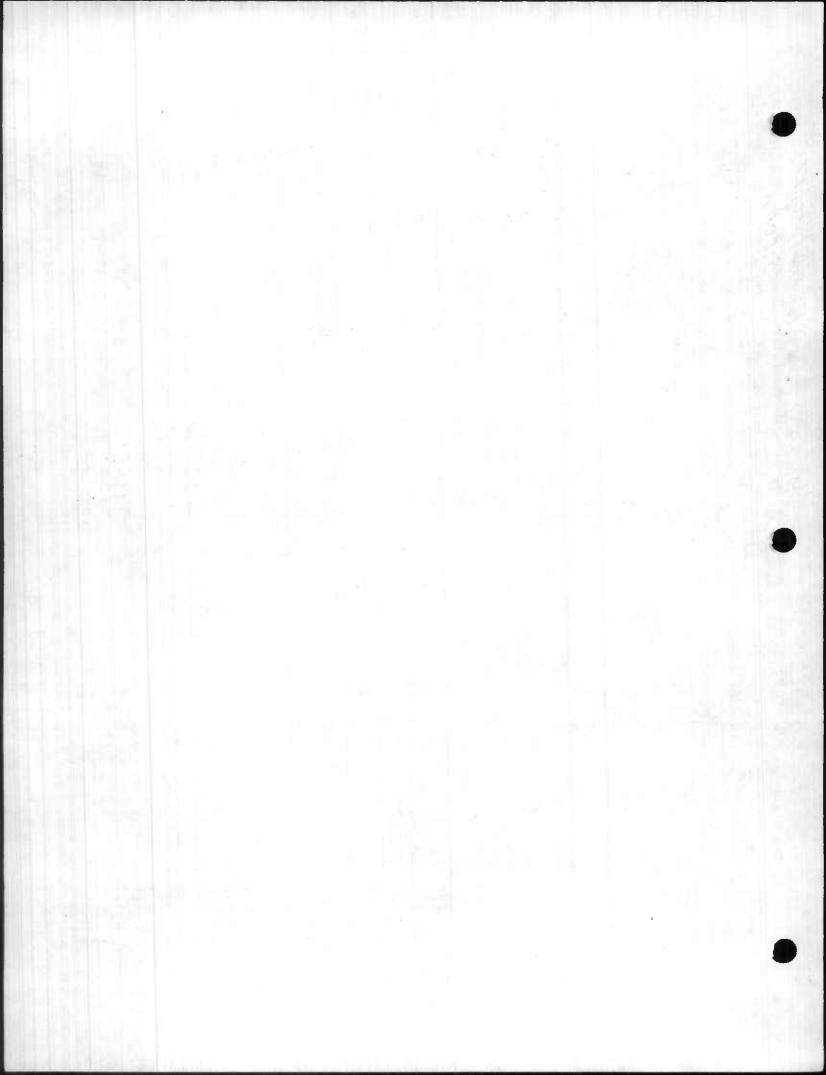
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOUSE Avenue; Frederich MO Amr Zaleanic Hegazi MO 801 TOLL HOUSE Avenue; Frederich MO 21701

State Registrar

edical

31. Dete filed (Month, Day, Year) OCT 0 3 2000 32. Registrar's Signeture

To the Hosp within 24 ho To the Fune completely fi



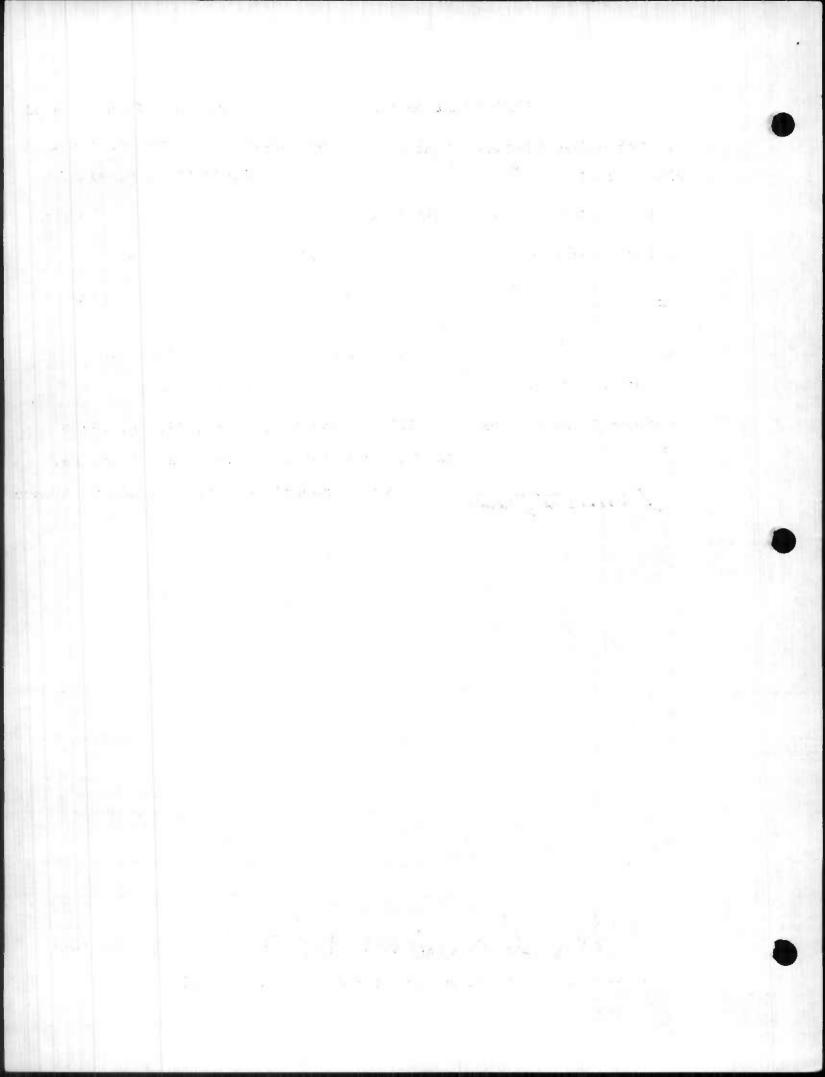
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** MARY ETHEL WELCH Sept. 24, 2000 7:00 AM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner St. Catherine's Nursing Center
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Emmitsburg Frederick County If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys 10M 3FF Director 214-52-2944 99 08-08-01 Maryland Usuel Residence of Decadent Peges 1 end 2 should be filled within 72 hours efter death with the Maryland nent of Heelth and Mental Hyglene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show Iry or other traumatic event, the Medical Examinet must be noticed. 10e Stete 10b. County 10c. City, Town or Location 10d, inside City Limits Pa. Adams County Fairfield Director 1 Yes 🏖 No 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 171 McCleaf Lane 17320 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 11. Marital Stetus 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: white 3 ⊠ Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) Homemaker Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Hugh J. Crawley Ethel Arminger 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Michael C. Welch, son 171 McCleaf Lane Fairfield, Pa. 17320
of Disposition (Neme of Date 20c. Location - City or Town, Stele 20b. Pieca of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition Surial 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Pege Department of Important: if any injury or once. St. Mary's Cemetery 9-27-00 Fairfield, Pa. 4 □ Donetion 5 □ Other (Specify) 21. Signefure of Funerel Service Licenses 22. Neme end Address of Fecility Davis Funeral Home 12525 Bradbury Avenue 23e. l'ert1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory artest, shock, or heert fellure. List only one ceusa on each line. Maryland intervel Between Onset end Deeth **Physician** /Medicai immediate Cause (Final disease or condition resulting in death) Examiner Examiner physicien end s the burial-transit thet the death certificate be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In death) Lest Due to (or as a consequ P.O. Box 68760, Physician/Medical Due to (or as a consequence of): attending p ed by the a Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, p 24a. Wes en eutopsy performed? 24b. Were eutopsy findings avellable prior to completion of cause of deeth? Completed peeu hes certificate 1 🗆 Yes 2 No 1 Yes 2 No Attending Physician: 25. Wes case referred to medical examiner?

1 Yes 2 No the funeral director, Be 28. Piece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Lo 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA this 27. Manner of Death 1 Delaturel 28e. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how Injury occurred 28c. injury at Work? After 5 Pending Hospital or Attending n 24 hours effer death.
 Funeral Director: After 2 Accident Investigation 1 Yes 2 No 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner steted. To the Hospi within 24 hou To the Funer completely fill 29e. Certifier Medical 29b. Signature and fitte & 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Alan Carroll, MD s. Seton Avenue Emmitsburg, Md. 21727 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State SEP 2 8 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

7			Certificate of	f Death	Reg. No.	00 32413
Physician	1. Decedent'e Neme (First, Middle, Last	y .	[A Ca	1100	2. Dete of Deeth Month Dey	Year 3. Time of Death
/Medical	11/avian	street and sumber)	VVa	4b. City, Town, or Lo	columber	2/, 2000 5155 County of Death
Examiner	4e Facility Name (If not institution, give	alliance Has	child	Baltin	nove	Dy Hurse Cin
Funeral	5. Social Security Number 6. Sec	7. Age (In yrs.	If Under 1 Yes		8. Dete of Birth	9. Birthplace (State or Fore Country)
Director	212-35-6417	OM 2007F 8	Yrs. Months Dey		NOV 6 19	
	Usuel Residence of Decedent					
dati de	10a. Stete 10b. County	10c. Crt	y, Town or Location			10d. Inside City Lim
or 28a-f sho be notified at Director	MARYLAND ANNE A	RUNDEL EDO	GEWATER 12 7 2 2 4		400 000	****
	10e. Street and Number		10f. Zip Code		Tog. Cit.	zen of What Country?
iner must iner must Funeral	140 TYDINGS DR	IVE 12. Was Decedent Ever in U,	2103	Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - American Indien,
Fun Fun	1 Never Merried 2 Married	Armed Forcas? 1 ☐ Yes 2 ☐ No	It Yes, specify Cu	ben, Mexican, Puerto	Ricen, etc.)	Black, White, etc.
by by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Detes:	1 ☐ Yes 2 🔼 N	o Specify:		Specify: BLACK
Scal Boat	15. Decedent's Edu (Specify only highest grad		16a. Decedant's Usuel Occ	upation	16b. Ki	nd of Business/Industry
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T In T	ISAIAH WATKINS		140 TYDINGS			
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100	1 Buriat 2 ☐ Cremetion 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from Stella	ametery, cremetory or other p		9/29/00	ANNAPOLIS, MD
and a	21. Signeture of Funeral Service Licens	600	22. Name end Add	1	3/23/00	MINIMI ODIO, IID
9 4 9	Hany 17 &	Ecese Moo4	82 WM. REE	ESE & SON	S MORTUAR	Y, P.A.
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sician	shock, or haert tailure. List only o	na causa on eech line.				Intervel Between Onset end Deelh
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miner	resulting in death)	e. Due to (c	or es e consaquance of):	Wille	NV C	1
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physician and s the burial-transit cdical Examir	Sequentially list conditions, if eny, leading to immediate cause. Enler Underlying Cause (Disease or Injury	. Bone Ma	may may	whant		2mon
	thal initieted events resulting in death) Last	Due to (o	. 1 1	1 1	1. /	- 10 /
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signed by the attendit d be detached for use d by Physician/I	Total significant conditions co	inibuting to deall out not rest	unting in the briderlying cause	givori ar r orc i.		No 3 Probably 4 Unki
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page 2					1□ Yes 2	No 1 □ Yes 2 □ No
director, pag	25. Was case referred to medical examiner?			26. Placa of Deet	h (Check only one)	
S D	1 Yes 2 No	Hospitel: 1 popalient 2	ER/Outpetient 3 DOA	Other: 4 Nursing Ho	me 5 Rasidance	5 ☐Other (Specify)
	27. Mannar of Death Netural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury 28c. In		28d. Describe how injur	y occurred
al Director: After tied in by the funeral Certification:	2 Accident Invastigation 3 Suicide 6 Could not be		M 1	Yes 2 No		
Director: d in by the ertificat	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, ferm, street, fectory, offic y)	6	28f. Location (Street en City or Town, Stete	d Number or Rural Route Number,)
ly filled or						
To the Funeral Direction of the Completely filled in Medical Cert	29a. Certifier (Check only one) 12 Certifying Phy 2 Medicat Exami	iner: On the basis of examina	wiedge, deelh occurred et the tion and/or investigation, in my	time, date end plece, opinion, deeth occur	end due to the cause(s) red et tha time, date end	and menner es staled. I pleca, end dua to the ceuse(s)
To the comple	29b. Signature and title of certifies	end menner steled.	29c. Lice	nse number	29d. Dal	e signed (Month, Dey, Year)
6 = 8	1. 01/	- 0 f.lls	MAR	EC-RE	Con	Louis bo 21 24
	30. Nems and address of person who o	ompleted cause at death (ten	n 2de) (Type Print)	apphine	Lok MD	emperal, col
	Tologo Ha	OK INC	nen Lan	aephine Part au	Lok MD	muland
State	31. Dete tiled (Month, Day, Year)	32. Registrer's Signe	dure		1100	ly will.
Registrar	CED 2 8 200	Syman	D Sooil	2		

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) sept. 22, Helen Witherbee Worthing 7:50 pm 2000 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death FutureCare-Chesapeake Arnold Anne Arundel If Under 24 Hrs. 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Aga (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 M 2 M F Months Davs Hours Yrs. 217-44-0255 85 Sept 21, 1915 Ohio Usual Residence of Deceden 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Tyes 2X No Chevy Chase Montgomery MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3703 Leland Street 20815 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 1 No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American indian, 11. Marital Status Biack, White, etc. 1 Naver Married 2 Married White 1 ☐ Yes 2 ANO Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Geological Survey Chemist 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middla, Last) Archie Worthing Experience Witherbee 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert Worthing/Nephew 6 Linda Lane, Severna Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 20a. Method of Disposition Sept 27 1 Surlai 2 ☐ Cremation 3 ☐ Ramoval from Stata Park Lawn Memorial Park Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2000 21. Signulure of Puneral Service Licensee 22. Nama and Address of Facility Barranco & Sons, Barranco & Sons, P.A. Severna Park FuneralHome 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Jem ex 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. cerebrovascular accident recurrent Immediate Cause (Final disease or condition resulting In death) ial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last extension 0 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? , gastrostomi 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 26. Plece of Death (Check only one) Other: Nursing Home 5 Residence 8 Other (Specify)

Examiner The law requires that the death certificate be executed physician end the buriel-transit Division of Vital Records, P.O. Box 68760, Physician/Medical deteched signed by t 2 Completed s certificate hes b al or Attending Physician: T s after deeth.

I Director: After this certificat ad in by the funeral director, p? Be

Physician

/Medical

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"natural", or items 23a or edical Exeminer must be r

it than 'nature the Medical E

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and 2 a important: if item 27 is m any injury or other

Physician

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Hygiana.

and Mental

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within

25. Was cesa referred to medical examiner? 1 Inpatient 2 ER/Outpatient 3 DOA

1 Yes 2 No 27. Manner of Death

5 Pending investigation

6 Could not be

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Natural Accident

3 ☐ Suicide

4 | Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of deeth (item 23a) (Type, Print) else ca E Jumpers

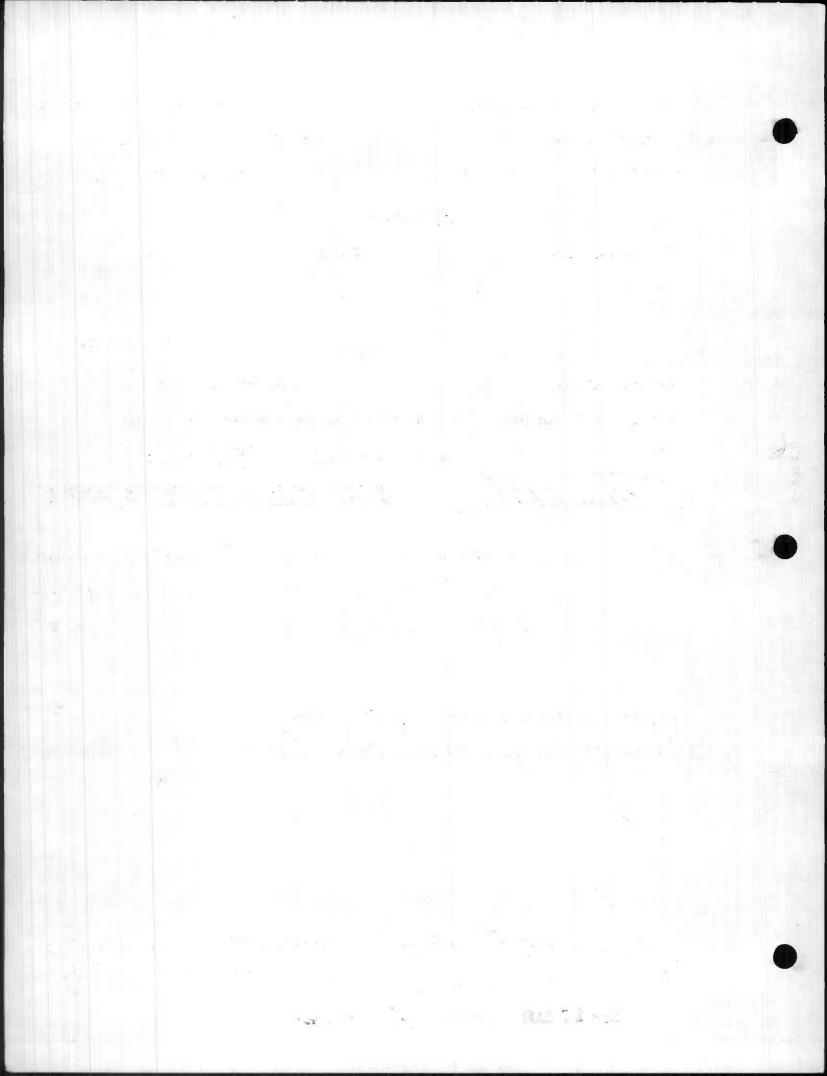
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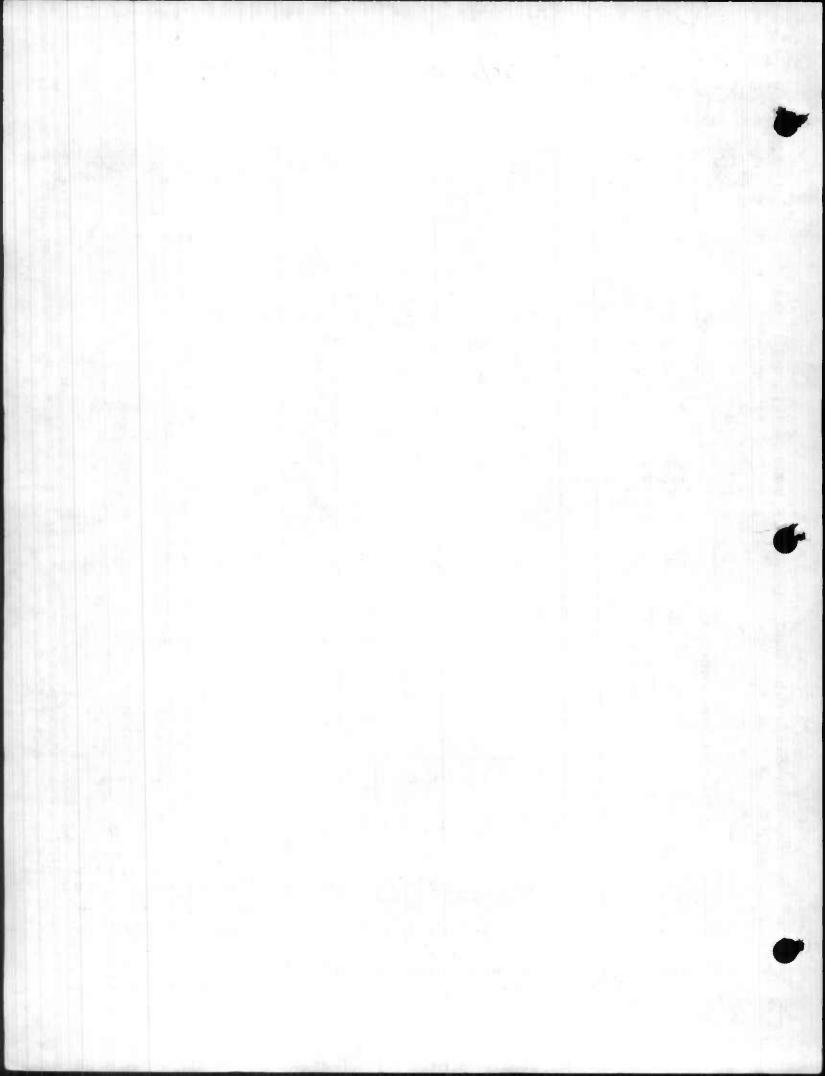
State Registrar

Certification: To

Medical

To the Hospital or within 24 hours aft To the Funeral Di completely filled in





00-5861-005 DAMON E. ADAMS JVW

Funeral

Director

or 28a-f show named be notified at

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Nems

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death

filed within 72 hours after

. Pages 1 and 2 should be fill tment of Health end Mental H tant: If Item 27 Is marked out Ith end Menta 27 Ie marked r traumatic e

other

permit. Page Department of Important: If any Injury or once.

Maryland 21215-0020

Saltimore.

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 32482 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 13, OCTOBER 2000 9:35 P.M. Damon Erik Adams /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 2518 MOLTON WAY BALTIMORE WOODLAWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dev. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) (Month, Day, Year)
May 05, 1 Days 1 M 2□ F Maryland Yrs. 21 219-02-0696 Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Directo Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2412 Bibury Lane #303 21244 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married 1 Yes 2 No Specify: **Black** þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12th 2yrs Warehouseman Freight Delivery 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Name (First, Middle, Last) Daniel Adams Jr. Hope Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Hope Maddox (Mother) 2412 Bibury Lane #303 Baltimore, Maryland 21244 20e. Method of Disposition 20b. Placa of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 10/18/00 Pikesville, Maryland Druid Ridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Caple Funeral Service 21. Signal Funeral Service Licensee 5502 Winner Avenue Baltimore, Maryland 21215 23a Fanter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or heart failure, just only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en autopsy

Physician /Medical Examiner

The law requires that the deeth certificate be axecuted

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page 2

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To the Hospital of within 24 hours all To the Funeral D completely filled

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Medical Certification:

after death.

Director: After this certifica

Box 68760.

P.0.

of Vital Records,

Division

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25. Was case referred to medical

1X Yes 2 No 27. Manner of Death

1 Neturat 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DO 100

28b. Time of Founds :21 PM of Injury - At home, farm, street, factory, Iding, etc. (Specify) 2518

Injury at Work? 1 Yes 2 No

on Wai

Other: 4 Nursing Home 5 Residence 6 MOther (Specify) SCENE

26. Place of Death (Check only one)

28d. Describe how injury occurred P

1 Yes 2 No

0 28f. Location (Street and Number or Rural Route Number City or Town, Steep) Nood

1 PYes 2 □ No

29a Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner es stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner steted. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signeture and title of Certifier 11

O.C.M.E.

OCTOBER 14,2000

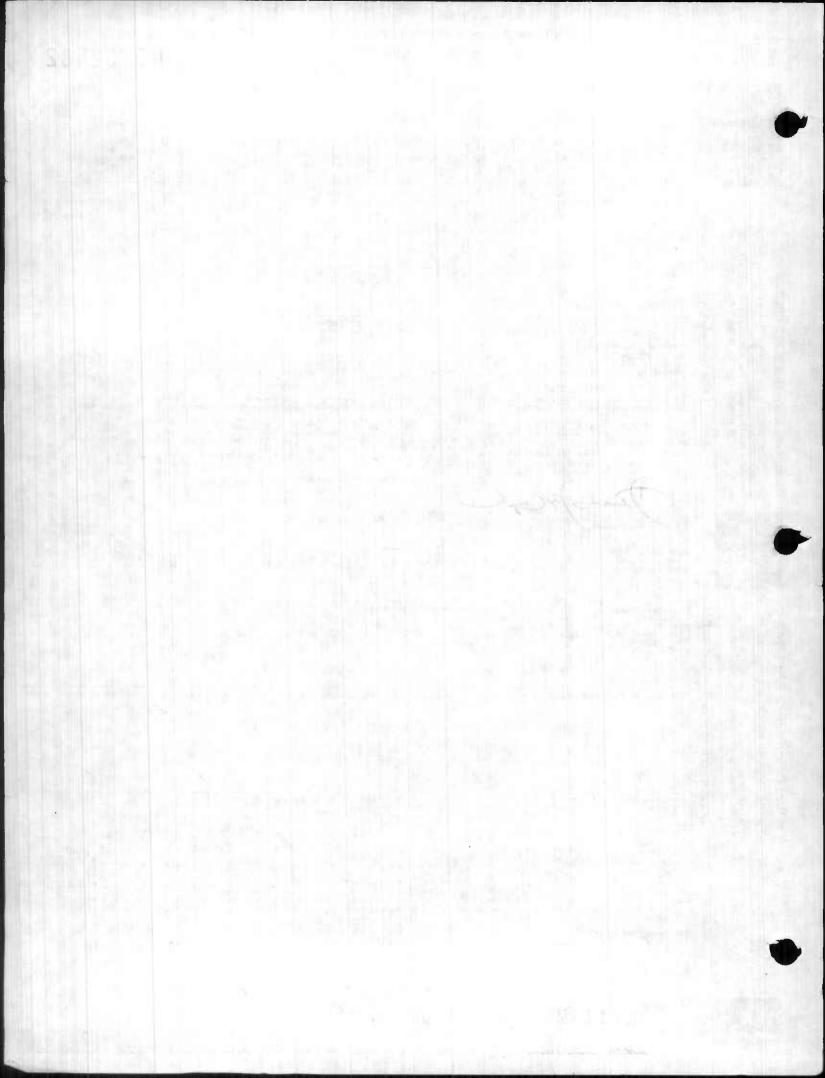
ess of person who completed cause of death (Item 23a) (Type, Print)

tane(111 Penn Street, Baltimore, Maryland 21201 ose es.

Dey, 6 2000 31. Date fil

32. Registrer's Signeture

State Registrar



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State of Maryland / Department of Health and Mental Hygiene 00 321, 92

20 010		Certifi	icate of Death	Reg.	No.	32403		
	Decedant's Nama (First, Middle, Last)			2. Date of Death	Day Yaar	3. Time of Death		
Physician /Medical	CLARENCE T. ALSTON	JR		OCTOBER	11, 2000	1556 PM		
Examiner	4a Facility Nama (If not institution, giva street and num	iber)	4b. City, Town, or L	ocation of Death	4c. County of Death			
	SINAI HOSPITAL		BALTIMORE	E CITY	NI	A		
uneral			Undar 1 Yaar If Undar 24 Hrs.	8. Date of Birth (Month, Dey, Ye	9. Birth	plece (Stete or Foreigintry)		
ector	213-62-1625 10M 20F	47 Yrs.	Signo Boyo Hours IVIIII	111-22-5	2	NY		
	Usuel Residence of Decedent 10a, State 10b, County	10c. City, Town or Location	20			104 1-14-04-11-1		
THE P			AT.			10d. Inside City Limit		
ust be notified at rail Director	MD NA	BALTIMORE						
be notified Director	10e. Street and Number		Of. Zip Code	10g.	Citizen of Whet Cou	intry?		
T E	622 N. AUGUSTA AVEN		21229		USA			
iner must Funeral	11. Marital Status 12. Was Decer	dent Ever in U,S. 13. Was lf Yas	Decedent of Hispanic Origin? (SI s, specify Cuben, Maxican, Puerto	pecify Yas or No- Pican, etc.)	14. Race - Aman Bleck, Whita			
PR	1 Never Married 2 Merried 1 Yes If Yes, Give	9 1 1 1	Yes 2 No Specify:		Specify: 12) n			
d by	3 ☐ Widowed 4 ☑ Divorced Year or Da			1.00	BLA	ICK		
Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent: (Give kind	s Usual Occupetion Tof work done during most of work VOT use retired)	king 16t	b. Kind of Business/In	ndustry		
a de	Elementary/Secondary (0-12) College (1-	40r 5+) ADMINIS			ALTIMORE	CITY		
	12 TH GRADE N/A 17. Father's Name (First, Middle, Last)	Homings		DF ne (First, Middle, Mai		City		
Be		20						
2		SR .		CORNICK				
	19a. Informent's Name/Relationship (Type, Print)		ddress (Street and Number or Ru			ip Code)		
	STANLEY ALSTON	20b. Plece of Disposition		HOODBRIDG		2193		
6	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from S	complex aremate	ry or other plece)		c. Location - City or T			
4	4 ☐ Donetion 5 ☐ Other (Specify)	KING MEMO	PRIAL PARK	10-16-00 RA	INDAUSTOI	WN, MD		
NA IN	21. Signature of Funeral Service Licensee	22. Na	me and Address of Fecility	DIAMONI	GEDVICE			
2 9	Days CH	5151	GHN C. GREENE BALTO. NATL' PI	KE RAIT	o mo	21229		
	23a. Pent. Enter the disease, or complications that ce shock, or heart failure. List only one cause on ea	used the deeth. Do not enter th	e mode of dying, such as cardiac	or raspiretory errest	i	Approximete intervel Between		
Examiner	resulting in death) Sequentially list conditions, if any leading to immediate	Due to (or as e consequent	V .	7				
as the burial-transit Aedical Examir								
ory the attending property of the attending	d							
d be detached for use	Pert II. Other significant conditions contributing to de	ath but not resulting in the under	tving cause often in Part I.	23b. Did toba	cco use contribute	to the cause of dea		
thys				1□ Yes		obably 4 Unknow		
be del								
a pa				24e. Wes en e		Vere eutopsy finding		
page 2 should				periorite		completion of causa		
Be Comp				1 Yas		Pres 2 No		
Ö	25. Wes case referred to medical		OC Plane of Dee		2010	2110		
Be	examiner? Hospitel:		Other:	th (Check only one)	а Пон — 10 —			
.To	1X Yes 2 No 1 o in 1 o		41	ome 5 Residence 28d. Describe how		-		
Certification:	1 □Naturel 5 □ Pending (Nont/	Dey Year) Injury	28c. Injury et Work?	Drivero	FMOTOR	venicle		
ICa Ca	3 Suicide 6 Could not be	of Injury - At home, ferm, street,		28f. Location (Street	et end Number or Ru	rel Boute Number.		
Ta	4 Homicide determined 200, Flooding buildin	g, etc. (Specify)	lectory, office	City or Town, S	Stete)	MA		
Ö	29a. Cartifier 1 Certifying Physician: To the	reet	surred at the time, date and stone	Dalt	-imore,	1-(0,		
edical	29a. Cartifier (Check only one) 1 Certifying Physician: To the base and menn	sis of examinetion end/or investi-	getion, in my opinion, deeth occu	red et the time, dete	end plece, end due	to the cause(s)		
completely filled in by the funeral Medical Certification:	29b. Signature end title of Contifier	BI SIGIOG.	29c. License number	294	Dete signed (Month	Day Year)		
8		MAR	OCME		CTOBER 12,			
	Tullan	~,0~(.D.				2000		
	30. Neme end actions of person who completed cause							
	Joseph Pesta		Street, Baltimo	re, Maryla	and 21201			
State		egistrar's Signeture	The control of the co					
gistrar	OCT 1 6 2000	France Ps						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEMS: #5,10F, 19B, 20B, PER PRINT G788 10-22-00 TRATE of Death

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 1. Decedent'a Nama (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Damon Ansel Brown OCTOBER 14,2000 02:43 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** BALTIMORE N/A JOHNS HOPKINS BAYVIEW If Under 1 Yaar | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dale of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours 1 M 2 F 25 Yrs. Feb 02, 1975 Director 216-84-2850 Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show 1 Nes 2 No MD N/A Baltimore Director the Medical Examiner must be notified 10f. Zip Code 21213 10e. Street and Number 10g. Citizen of What Country? Harris 23s or 4027 Ardley Avenue 21202 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 IXYes 2 ☐ No If Yes, Giva Year or Dales: 14. Race - Americen Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0020 8 1 ☐ Yas 2 ☐No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Elementery/Secondary (0-12) 12th College (1-4or 5+) Landscaper State of Maryland 18. Molhar's Nama (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middle, Last) Marked or Pages 1 and 2 should be ment of Health and Mental Aaron Henry Brown Mary Elizabeth Hicks pun a 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trea 2028. Mary E. Hicks (Mother) 4027 Ardley Avenue Baltimore, Maryland 21202 Saltimore, 20b. Place of Disposition (Name of emetery, crematory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition REFN MONT CFMETERY. 10/20/00 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Caple Funeral Service 5502 Winner Avenue Baltimore, Maryland 21215 or complications that ceused the death. Do not enter tha mode of dying, such as cerdiac or respiratory arrest, List only one ceuse on each line. Approximete Interval Between Onsel and Death **Physician** /Medical fmmediate Cause (Final disease or condition resulting In death) gunshot wounds Multiple Examiner Due to (or es a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in daath) Last Due to (or as a consequence of): Box 68760 Due to (or as a consequence of) signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were eutopsy findings availabla prior fo completion of ceuse of death? 24a. Was an autopsy performad' pege 2 1 PYYes 2 □ No 1 Yas 2 No certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Yes 2□ No Hospilal: 1 ☐ Inpatient 2 N ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28c. Injury al Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Netural Injury 5 Pending Subject was shot effer death. AM 1 ☐ Yes 2 No 2 Accident Investigation 10-14-2000 unknown 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 5400 Force Road 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide Street | Sidewalt

Baltimore City, Maryland

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

of Vital Division 24 hours Medical To the P

P.O.

29b. Signature and title of certifier 30. Name and address of person who completed ceuse of dealh (Item 23a) (Type, Print) Radentz 5,

29d. Dale signed (Month, Day, Year)

29c. License number O.C.M.E. OCTOBER 14,2000

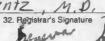
111 Penn Street, Baltimore, Maryland 21201

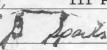
State Registrar

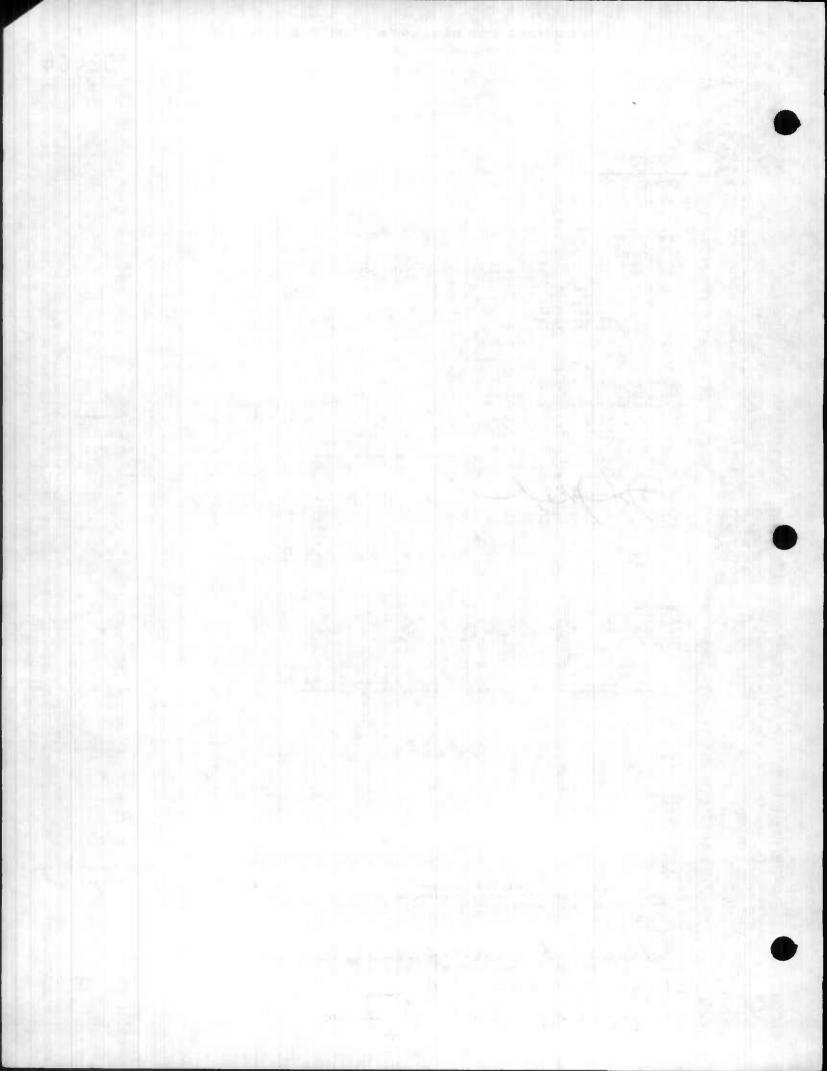
DCT 1 6 2000 **DHMH 16 Rev 6/95**

stephen 31. Date filed (Month, Day, Year)

29a. Certifier (Check only one)

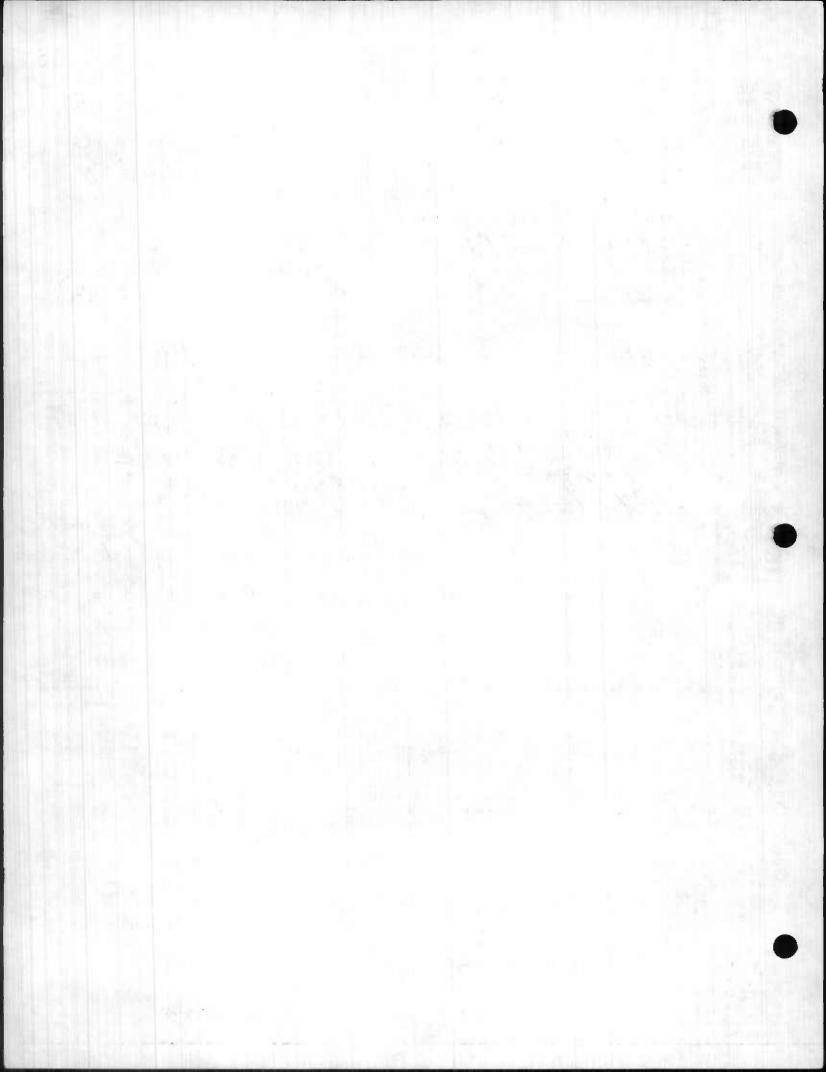






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AMEND IT	TEM:31 PER C.V.R	State of Maryland / J	Department of H	ealth and Mer Death	ntal Hygiene	.00	32485
Physician /Medical	1. Decedent's Nama (First, Middla, Las Bertha	5. Brown			Deta of Death Month	Year 2000	3. Tima of Death 5 Pi M
Examiner Funeral	5. Social Security Number 6. Se	x 7. Age (In yrs. last bir	thday) If Under 1 Year	b, City, Town, or Locati BA TIMO If Under 24 Hrs. 8. Hours Min.	Data of Birth (Month, Day, Year,		placa (Stata or Foraign
Director	Usuel Residence of Decedent 10a. State 10b. County	10c. City, Tow	Yrs. Days	I A	pril 23,1	913W.	Od. Insida City Limits
020 urs after death with the Manyland ali, or items 23s or 28s-f show Exercises from the notified at by Funeral Director	MD Baltin	nore Wood	Olawn 10f, Zip Code		10g. Ci	tizen of What Cou	1 □ Yas 2 ☑ No
(free death with the Ma r freme 23a or 28s-fa singer must be notified Funeral Director	11. Marital Status	12. Wes Decedent Ever in U,S.	2/20	spanic Origin? (Specify	Yas or No-	SA 14. Race - Amaric	
5 28 5	3 Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Datas:	1 Yas 2 No	n, Mexican, Puerto Rici Specify:		Specify: B	ack
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mental Hygiene. The marked other than "natural", or traumatic event, the Mid cal Exercity To Be Completed by F	15. Decedent's Edi (Specify only highest grad		Decedent's Usual Occupa (Give kind of work done d lifa. DO NOT use retired)	furing most of working	16b. H	(ind of Business/In OM C	dustry
Baltimore, Maryland 212: permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than more. To Be Comp	17. Fatbar's Nama (First, Miogla, Last)	Jn		18. Mother's Name (F)	int, Middle, Maidei 1000C	Sumame)	
re, Mar 1 and 2 sho Health and om 27 is m	19a Informant's Name/Ralationship (7	nt-daughter 6	Mailing Address (Street a 20 009 H	III RD. WO	od/awn	, MD. á	1207
Baltimore, permit. Pages 1 ar Department of Heal Important: if Item.? any Injury or other once.	20a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Densition 3 Other (Specify, 21. Signature of Juneral Service Licens	Removal from Stata King /	ny, crematory or other place MEMOTIAL P	ark 10/1	14/00 Ran	dallstou	un, MD.
Balti permit. Departi importa any lnjk	Jay 1 M	instance that caused the death. Do	1948 Freds	siffer Pas	S Balfa	mb. 21	AQ9 Approximete
Physician /Medical Examiner	Immediata Causa (Final disaase or condition rasulting in deeth)	ne cause on each line. Non Small		lung C			Interval Batween Onsat and Daath
cords, P.O. Box 68760, v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit letted by Physician/Medical Examiner	Cause (Disease or injury that initiated events	0	consequence of):				
Vision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certificate actor. After this cartificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the iffication: To Be Completed by Physician/Medic	Part II. Other significant conditions co	entributing to death but not resulting in	on in Part I.	23b. Did tobacco use contribute to the cause of d			
Division of Vital Records, or Attending Physician: The law requires the affect death. Director: Affer this cardificate has been signed by the funeral director, page 2 should be entitication: To Be Completed by	Primary	14 pertensie	η		24a. Was an eutoperformed?	co of	ara autopsy findings ailable prior to impletion of cause death?
f Vital Representations of Vital Representatio	25. Wes case rafarred to medical			26. Place of Deeth (C	,	M No 11	☐ Yas 2☐ No
of V hysici his car il direc	axaminar? 1 Yas 2 No	fospital: 1 Inpatient 2 ER/Ou	tpatient 3 DOA Othe	97: 4□ Nursing Homa	5 Residence	6 □Othar (Speci	y)
ion of noting Physics Affection of funeral ation: 1	27. Manper of Death 1 Metural 5 Pending 2 Accident invastigation		Firms of 28c. Injury Work	yet 28d Yes 2 No	. Describe how inju	iry occurred	
Division or To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At homa, fa building, etc. (Specify)	rm, street, factory, office	28f.	Location (Street a City or Town, Stat		el Route Number,
Hosp 24 hou Fune stely fil	29a. Certifier (Check only one) 1 ▼ Certifying Phy 2 □ Medical Exami	sician: To the best of my knowledge ner: On the basis of axamination an and manner stated.	o, death occurred at the time d/or investigation, in my op	e, date and place, and pinion, death occurred a	due to the cause(s it the time, date en	e) end mannar as a d plece, and dua t	tated. o tha ceusa(s)
within To the comple	29b. Signature and title of certifier		29c. License	number	29d. Da	ate signed (Month,	Day, Year)
J.M.	mile	4.17-		5069	10	1-10-0	0
State	30. Nama and addrass of person who co	smpleted cause of death (Item 23a) 5 tm	(Type, Print) 3100 Wy	man fa	ak Arein	e Ba	Himore, MD
Registrar	10-10-00	DOT 16	2000 Lan	eva fi	Aporto	à	
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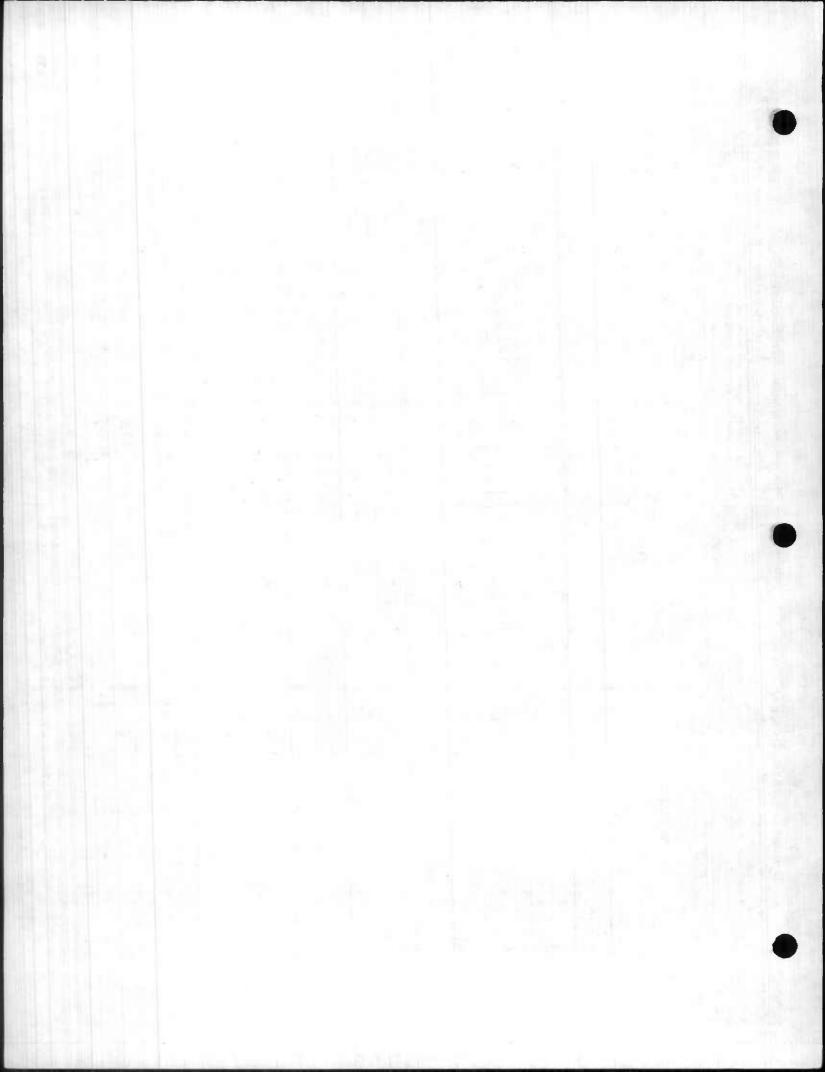
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dev Month **Physician** FRANCES BAKER OCT. 14 2000 5:10am /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ROLAND PARK PLACE BALTIMORE If Linder 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9. Birthplaca (Stete Country) 05/05/1899 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** Months Days 1 M 2 R F Yrs. 216-46-1598 101 Director Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show 1 Yes 2 No MD N/A Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 WEST 40TH STREET 21211 USA Nerne 23a Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, atc. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Maritel Status 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No If Yas, Give Yeer or Detes: 'natural', or altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE 3XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4YRS Elementery/Secondery (0-12) HOUSEWIFE HOMEMAKER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Department of Health and Mental important: if flam 27 is marked or any injury or other traumatic eventice. Pages 1 and 2 should be RALPH ROBINSON ELLEN GOWEN To 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) HENRY S. BAKER JR. (SON) 16916 WESLEY CHAPEL RD. MONKTON, MD. 21111. 20b. Plece of Disposition (Nema of cemetery, cremetory or other place) 20e. Mathod of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from State GREEN MOUNT CREMATORY10/16/2000 BALTO., MD. 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name end Address of Fecility
HENRY W. JENKINS & SONS CO. 21. Signeture of Funeral Service Licensee 4905 YORK RD. BALTO., MD. 1110111 21212. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** 7 JAYS /Medical Immediate Ceuse (Final PAGUMONA diseese or condition resulting in daath) Examiner Due to (or as e consequence of): Physician/Medical Examiner Z5 721 LUNE DISTAGE CHRONIC DBSTRUCTE certificate be executed physician and s the bunal-tran Sequentially list conditions, if eny, leading to immediate causa. Entar Underlying Cause (Diseese or Injury that initialed events resulting in death) Last Due to (or as a consequence of) Box 68760 Due to (or as e consequenca of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1X Yee 2 No 3 Probably 4 Unknown ASCID by Records. 24b. Were autopsy findings evailable prior to completion of cause of daath? Completed 24a. Wes an autopsy page 2 s 200 No 1 ☐ Yes 2 No 1 Yes certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical axaminar?

1 Yes 2 No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Menner of Deeth 28a. Dete of Injury (Month, Dev Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Affer 5 Pending invastigation 1 Natural death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, data end place, and due to the cause(s) and mannar es steted.

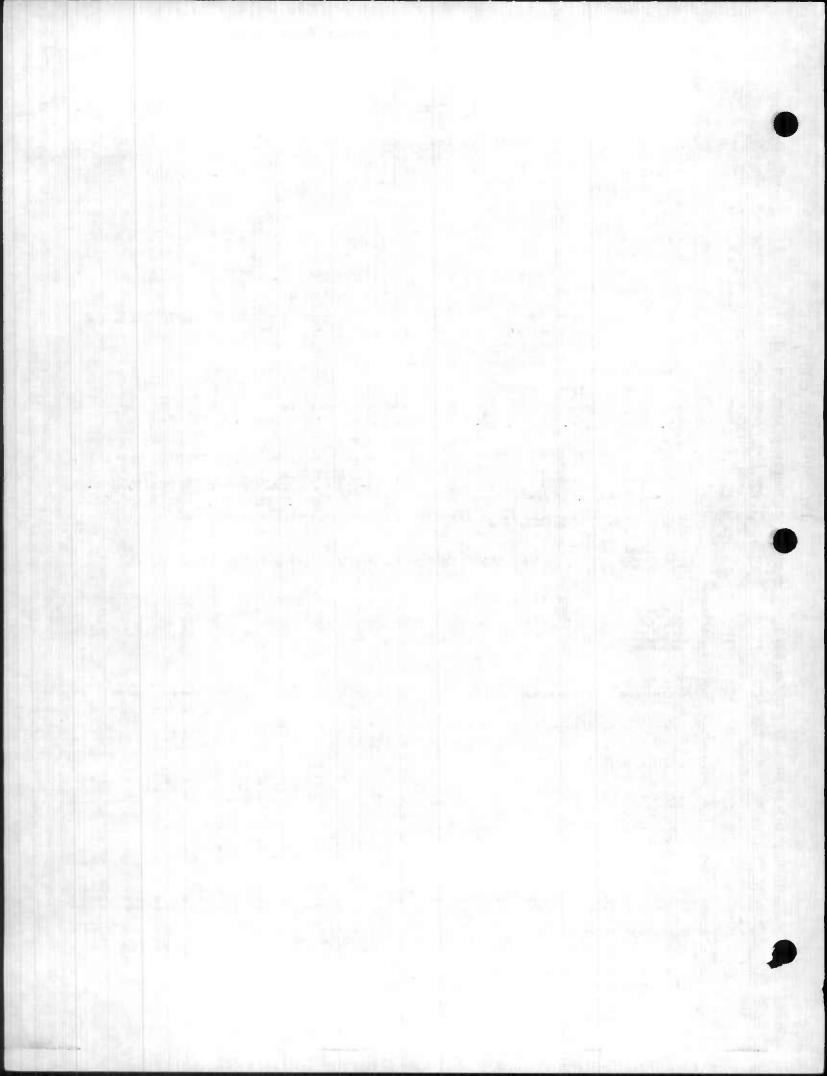
Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the tima, data end place, end due to the ceuse(s) and mannar statad. 29a, Certifian (Check only one) 29b. Signature and title of bestifier 29d. Dete signed (Month, Dev. Year) 29c. License number 12399 OCTOBER 14, 2000 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES O, DONOVAN III M.D. 6565 N. CHARLES ST. TOWSON, MD. 21204. 31. Dete filed (Month, Dey, Year)
OCT 16 2000 32. Registrer's Signature Registrar



ysician	1. Decedent's Neme (First, A	fiddle, La	st)	FYF		11412		2. Date of Deat Month	Day	Yeer	3. Time of Deeth	
cal	. = 10. 11. 11. 11.			1	Joan	Brehm	4b. City, Town, or l	october	12200		2:09pm	
iner	Franklin Squa	11	os Pita	1 4 1	29		Rosedale		8altimore		0	
	5. Social Security Number 212-34-5501	6. 5			s. last birthday) Yrs.	If Under 1 Ye Montha Day	ar If Under 24 Hrs.	8. Dete of Birth (Month, Day Feb. 1		9. Birthpi	ece (Stete or Foreign) Land	
	Usuel Residence of Deceder 10a. Stete 10b. Co	_		10c. C	ity, Town or Lo	cation				10	od. Inside City Limits	
tor	Maryland	Ва	altimore	9			Essex				1□ Yes 2 No	
al Dire	10e. Street and Number 1503 Nicolay	Way				10f. Zip Code	21221	1	Og. Citizen of V Unit	What Count ed St		
by Funeral Director	1 Never Married 2 Married 1 Never Married 2 Named 1 Yes, 3 Wildowed 4 Divorced Yeer of 15. Decedent's Education			rces? 2\ No	No 1 Yes 20XNo Specify:					e - Americe k, White, e		
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years 16a. Decedent's Usual Occupation (Give kind of work done during model) (Give kind of work done during model) (Bive Library Secondary (0-12) (Bive L						ne during most of wor ired)	king	16b. Kind of Bu	siness/Ind		
		7. Fether's Neme (First, Middle, Last) 18. Mother							Maiden Sumem			
other traumatic event, the M		Thomas Wilson Davis Dorothy Nellie Hood 19a. Informent's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta									0-43	
	19a. Informent's Name/Rela Mr. Clarence			Sr.	1503	Nicola	y Way Ess	ex, Mary	land 2	State, Zip 21221	Code)	
	20e. Method of Disposition ★②Buriel 2 ☐ Crema 4 ☐ Donetion 5 ☐ Other			Cinta	cametery, cren	sition (Neme of netory or other) f Faith	Cemetery		20c. Location -		wn, Stete	
any Injury or	21. Signature of Funeral Ser	vice Lice	500			Name and Adouda-Ruc	ress of Facility Experience	Home of			c. 222	
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	{	b	Due to	(or as a conseq (or as a conseq (or as a conseq	uence of):						
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Certifi	29a. Certifier (Check only 20 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner as stated.											
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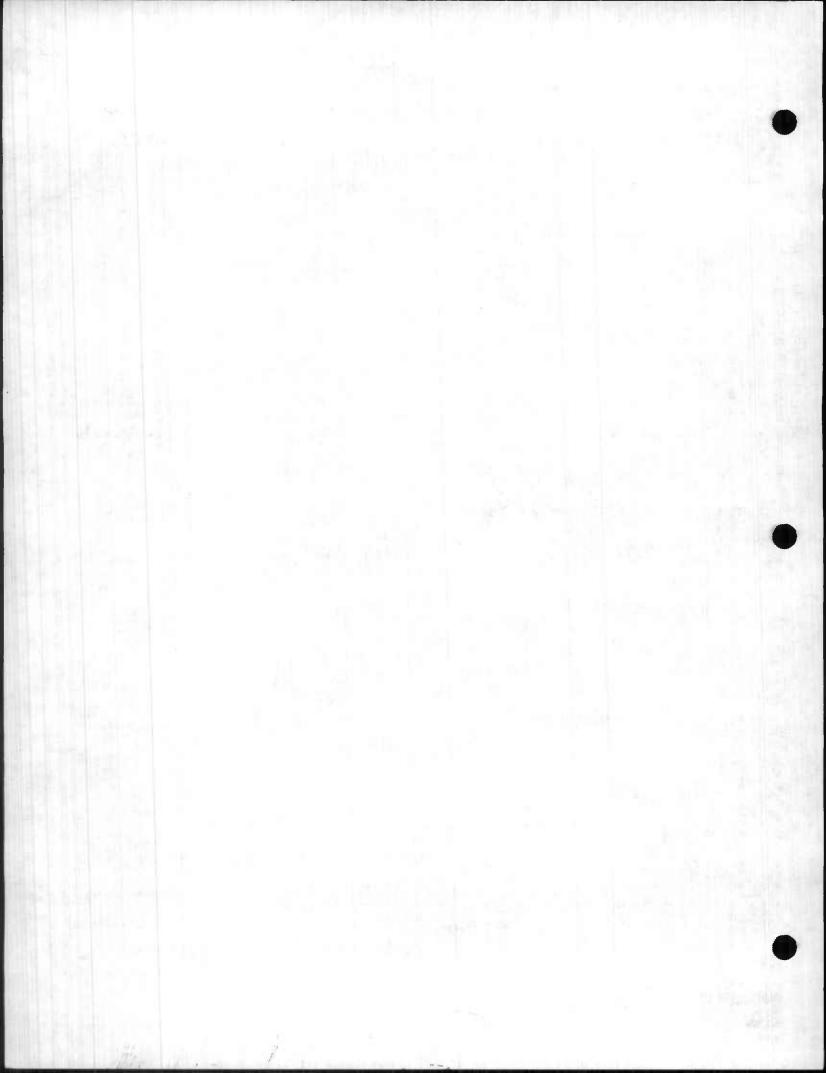
DHMH 16 Rev 6/95

BreHm, Dorothy



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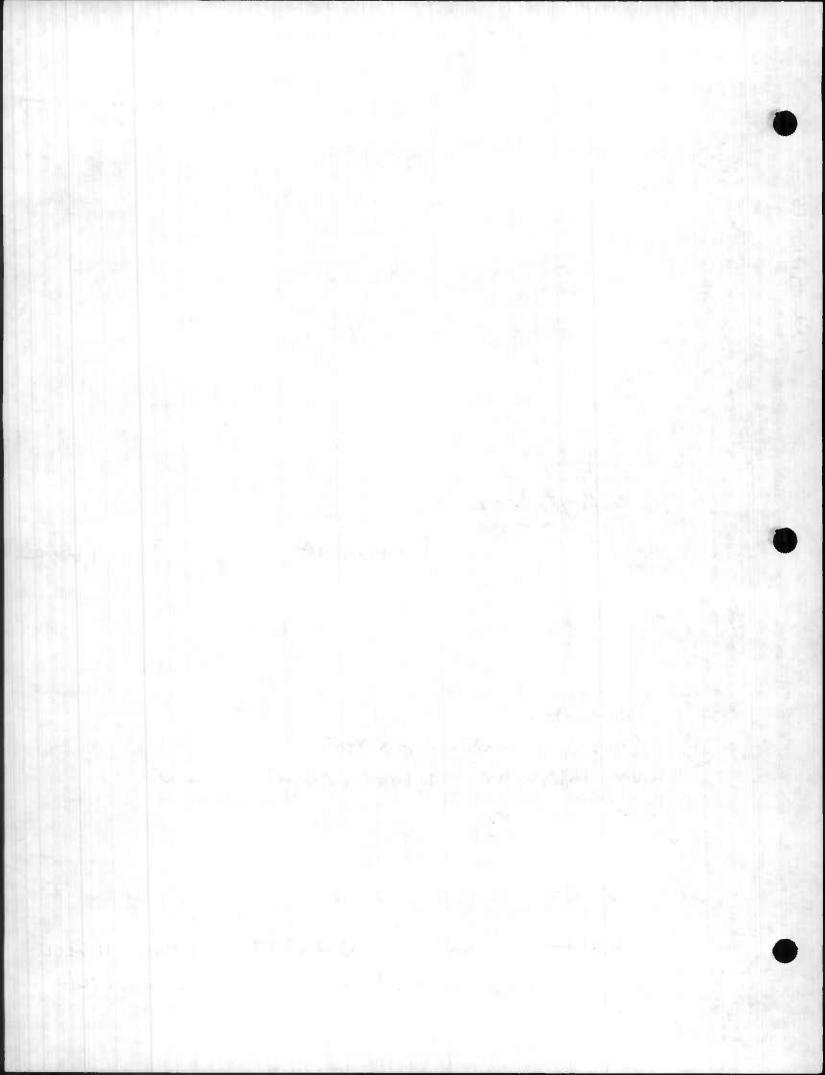
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State of Maryland / Department of Health and Mental Hygiene 00 32489

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Vita	Physician: The this certificate ral director, page	Be	25. Was casa raferred to medical axaminar?	Hospital:			0		ot Death (Check	only ona))			
	this cal dir	10	1 Yes 2 No	1 Inpatier			DUA		sing Homa 5				y)	
L C	After funer	lo	27. Manuer of Death Naturel 5 Pending	28a. Data of Injury (Month, Day	Year) 28b. T	njury M	28c. Inju Wo	ork?]Yas 2 □ N		CIDS NOW	injury occur	100		
Division of	il or Attending Physicien: The I after death. Director: After this certificate hi d in by the funeral director, page	Certification:	2 Accidant 3 Suicida 4 Homicida invastigation 6 Could not b datarmined						28f. Loca	ation (Stre or Town,	et and Numi Stata)	per or Rura	/ Routa	Number,
	the Hospital of the Faneral Capital filled	edical C		ysictan: To the best of niner: On the basis of and manner stal	axamination and									usa(s)
1	To H	ž	29b. Signature and title of certifier		4 13 13 11		29c. Lican	sa number		290	d. Data signa	d (Month,	Day, Ye	iar)
	1		1 Soft		MS		0	439	77	0	whose	1	12	000
	121	-	30 Nema and address of person who	complated causa of da	ath (Itam 23a)	Type, Print)	1 00	· i c	1 2	1	0 1	.)	10	1-1
	Sta	te	31. Date field (Month, Day, Year)-	- 32 Registre	30(T//	ing ya	ו אינע	+ (Jan 3	ハイル	NC · W	N) L	10	0'



State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) BAIRD 10:15 AM 2000 OCTOBER 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not Institution, give street and number) Good Samaritan Hospital Baltimore H Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)

Hours Min. February 26, 1920 Mary land 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1□M 2QF Yrs. 80 10b. County 10c. City, Town or Location 10d. Inside City Limits XX Yes 2 No Baltimore 10f. Zip Code 10g. Citizen of What Country? 617 St Dunstan's Road 21212 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 200 No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ₩ Widowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Rudolph Lemke Ethel Dorothy Pope 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) DTR 1506 Ivy Hill Road Cockeysville, Maryland 21030 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State 1XX Buriel 2 Cremetion 3 Removal from State Dulaney Valley Memorial Gardens 10-16-00 Lutherville Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Service License Mitchell-Wiedefeld Funeral Home Inc. enakls 6500 York Road Baltimore, Maryland 21212 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death WEEK ISCHEMIC BOWEL Due to (or es e consequença of). Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Jonknown 24a. Was en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

ss 1 and 2 should be filed within 72 hours after death with 1 of Heelth and Mental Hygiene. Ifem 27 is marked other than "natural; or items 23a or 2 other traumatic event. In a Mental Exp. Maryland 21215-0020 Baltimore, Pages 1 permit. Pages Department of Important: If it any injury or o

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

Directo

Funeral

by

Completed

DOROTHY

5. Social Security Number

Usuel Residence of Decedent

N/A

213-20-6445

10e. State

Maryland

11. Merital Status

10e. Street and Number

Barbara B. Shaw

20e. Method of Disposition

/Medical Examiner hysiclan and the burief-transit The lew requires that the death certificate be axecuted Box 68760, P.O. of Vital Records, Physicien: Division or Attending s aftar deeth. filled in by To the Hospital 24 hours

Physician

Immediate Ceuse (Final disease or condition resulting in deeth) Physician/Medical Examiner Sequentially list conditions, if eny, teading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. ACUTE MYOCARDIAL INFARCTION, by Be Completed ATRIAL FIBRILLATION, LEFT LEG ARTERIAL HYPERTENSION, CONCESTIVE MEART FAILURE EMBOLI 25. Wes case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Deeth 28e. Dete of tnjury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Fune completely fi 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) end manner stated. (Check only one) 29b. Signature end title of certifier

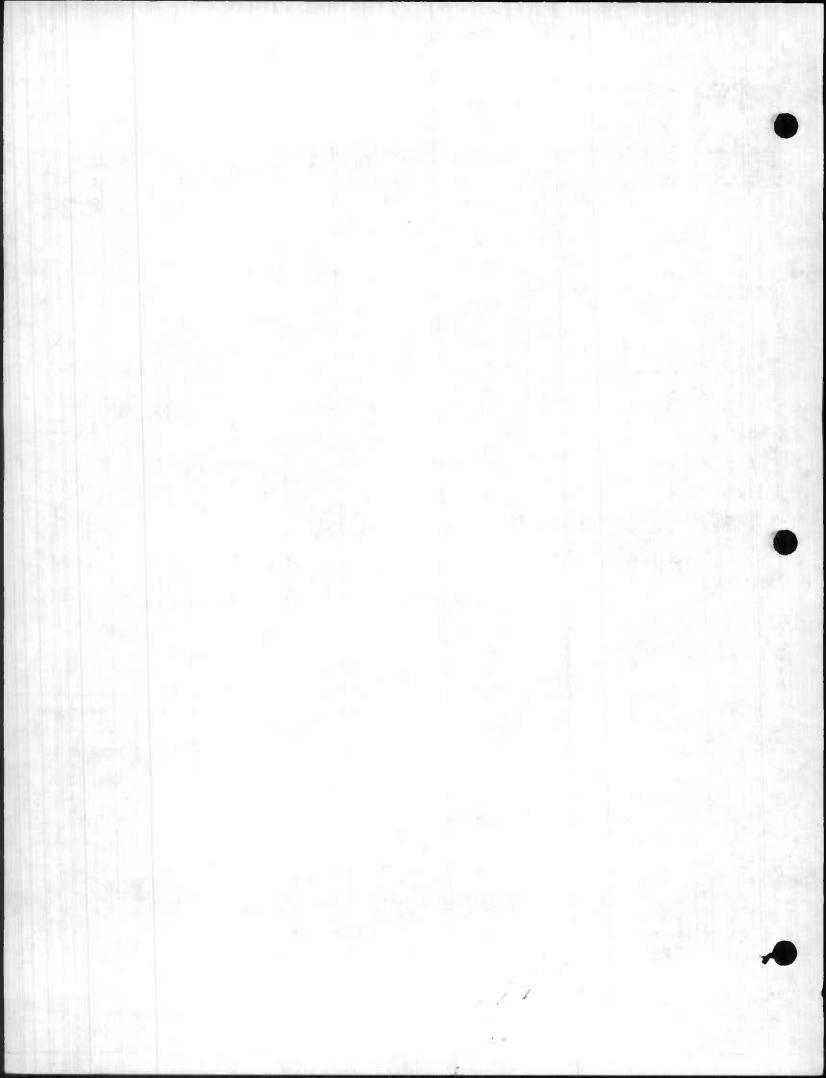
12564 OCTUBER 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 560) LOW RAVOY BOULEVARD, BALTIMONE, THUY. N. NGUYEN 6000 SAMARI MAN MUSPITTAL ELIZABETH

Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) OCT 1 6 2000

32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene 00 221, Q1

				tificate o			Reg. No.			
Physician /Medical Examiner	Decedent's Neme (First, Middle, WILLIAM H. CARE As Facility Name (If not institution, see the content of the cont	ROLL			4b. City, Town, or	2. Date of Dee Month OCTOBER Location of Deeth	Dey Yeer		3. Time of Death 9:20 P.M	
Funeral	STELLA MARIS	HOSPICE Sex 7. Age (In year)	rs. lest birthday)	If Under 1 Yes		8. Dale of Birth (Month, De)			e (State or Foreigi	
Director	217-05-6451 Usuel Residence of Decedent	8°	7			8/18/1	3	VIRGI	NIA	
show ed.at	MD BALT		City, Town or Loc		N CD			10d.	Inside City Limits	
on the Maryin or 28e-1 sho be notified at Director	10e. Street and Number	LIPORE	LOCH RAV	10f. Zip Code			10g. Citizen of	What Country	7	
	1709 EDGEWOOD	ROAD		21	234		HCD			
our sher death visit, or here 23s Examiner must by Funeral	11. Maritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces?			f Hispenic Origin? (uben, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Rac Bla	e - American ck, White, etc		
ud within 72 ho yglene. wr then "netur rt, the Medical. Completed	15. Decedent's (Specify only highest the Elementery/Secondery (0-12)		(Give I	lent's Usual Occ kind of work don OO NOT use reti	ne during most of wo	orking	16b. Kind of B	usin ess/ind us	stry	
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thould be 15 and Mental H marked off martic ever To Be	WILLIAM CARROL				ELEANC	R ELLIOT	τp			
2 shock and N is main is main in main	19e. Informent's Name/Reletionship		19b. Mailin	g Address (Stre	et end Number or F		_	Stete, Zip Co	ode)	
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Deg Man	1/	. 1 //	Tr.	HE TOUN	CONT ETTENTO	AL HOME,	P.A.			
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Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a Prostate		354	H RAVEN E trying, such es cerdie	or respiretory er	woon, M	D 212	86 pproximete terval Between nset end Death	
Medical be executed as the burial-transit as the burial-transit edical Examiner	Immediate Cause (Final disease or condition	a. Prostate Due to	Cancer	uence of): uence of):	lying, such es cerdie	c or respiretory er	rest, M	I Alico	terval Between	
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aw requires that the death certificate be executed to a second by the attending physician and 2 should be detached for use as the burial-transit pleted by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	a. Prostate Due to	Cancer o (or es e conseque) o (or es e conseque)	uence of): uence of):		23b. Did t	obacco use co Yee 2 □ No en eutopsy med?	antribute to ti	ne cause of death bly 4 Unknow e eutopsy findings sble prior to letion of cause ath?	
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Attending Physicien: The law requires that the death certificate be executed an order death. Attending Physician and sector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burlat-transit and by the funeral director, page 2 should be detached for use as the burlat-transit and by the funeral director. To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Part II. Other significant conditions 25. Wes case referred to medical exeminer? 1	a. Prostate Due to b. Due to c. Due to d. B contributing to death but not a Hospitel: 1 Inpatient 2 28e. Date of Injury (Month, Dey Year, Inpatient 2 28e. Pleca of Injury - A	Cancer o (or es e conseque) o	uence of): uence	26. Place of Do Other: 4 Nursing slury et Vork? Yes 2 No	23b. Did t 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	obsecto use co	24b. Were aveile composed of de 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ne cause of death ne cause of death output eutopsy findings able prior to bletton of cause ath? Yes 2 No Hospice	

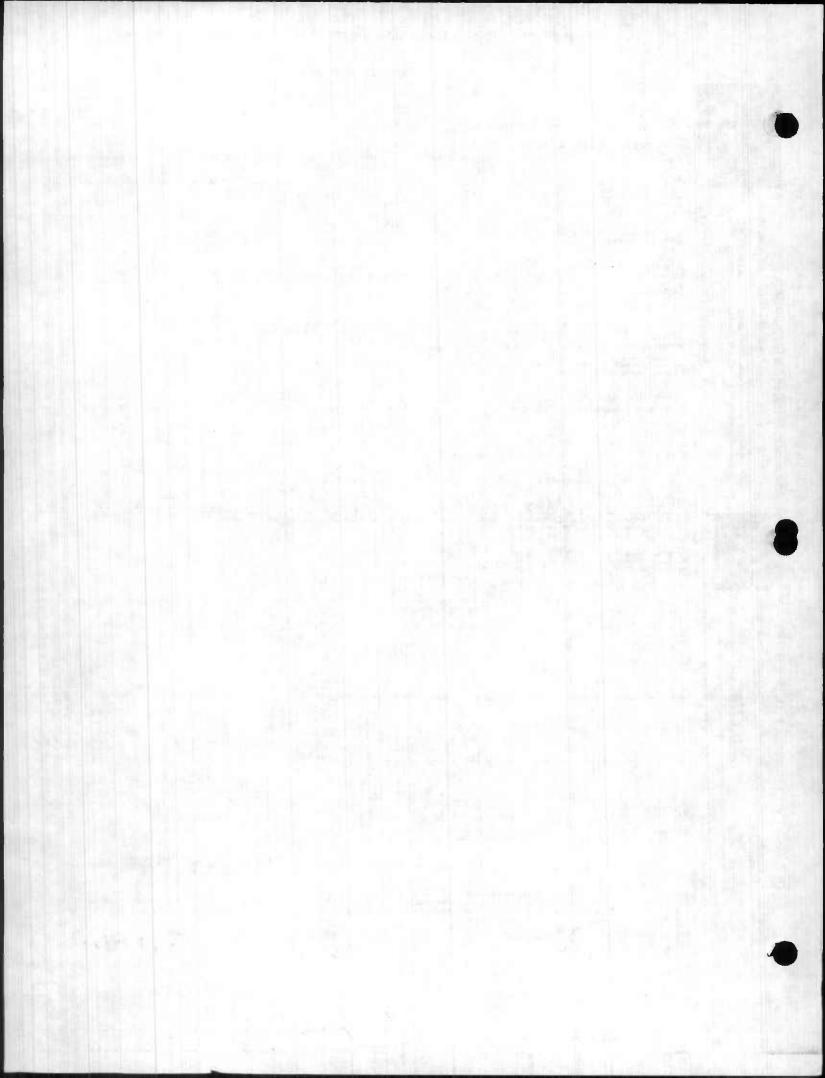
State Registrar

DHMH 16 Rev 6/95

31. Dete filed (Month, Day, Year)

32. Registrer's Signeture





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Robert Porter Crigger 10 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death N/A Eldulace Balto Coller manor If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplaca (Stete or Foreign Country) Hours Months July 3, 1915 VA 220-05-1667 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Lansdowne 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 1/2 Ridge Ave. 21227 U.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Bus Driver Transportation 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida Bridgeman Timothy Crigger 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 10 N. Calvert St. Suite 620 Baltimore, MD. 21202 Arthur L. Drager / lawyer 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 □ Burial 2 □ Cremetion 3 □ Removel from Stete 10-17-00 4 ☐ Donetion 5 ☐ Other (Specify) Loudon Park Cemetery Baltimore, MD 21. Signeture of Funeral Servica Licensee 22. Name end Address of Fecility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediete Cause (Finel diseese or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evallable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

altimore

Box 68760

of Vital Records, P.O.

Division

Hospital 24 hours a

To the To the

Physician

/Medical

Examiner

Directo

Be

MD

Funeral

Director

288-1

ò

Physician/Medical by Completed Be

Certification: or Attendation of the Charles

25. Wes case referred to medical examiner? 1 Yes 2 No

27. Menner of Death 1 XNetural 5 Pending investigation 2 Accident

6 Could not be determined 3 Sulcide 4 Homicide

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year)

28b. Time of

soe, ND

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Tyes 2 □ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title of cartifier

0052940

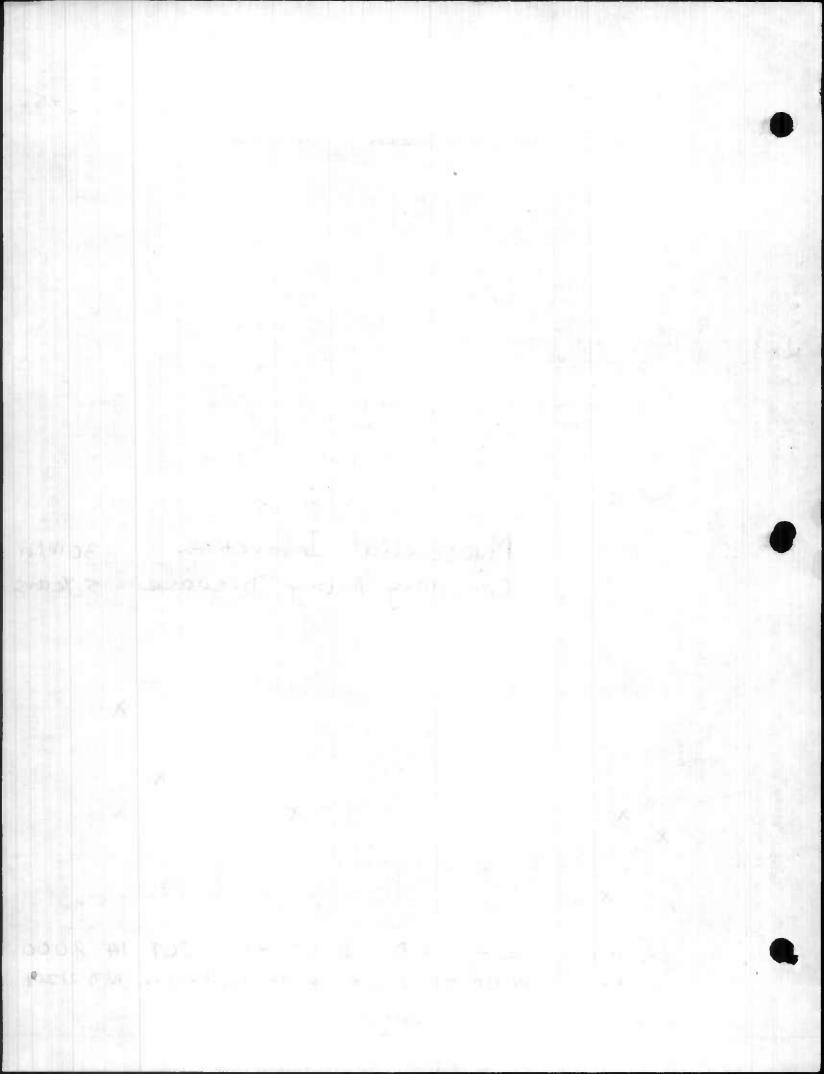
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SANTAY P. SHAH, ND 821 N. EUTOW #407, Baltimore, MD 21201

31. Date filed (Month, Dey, Year) State Registrar

edical

29e. Certifier (Check only one)

32. Registrer's Signeture



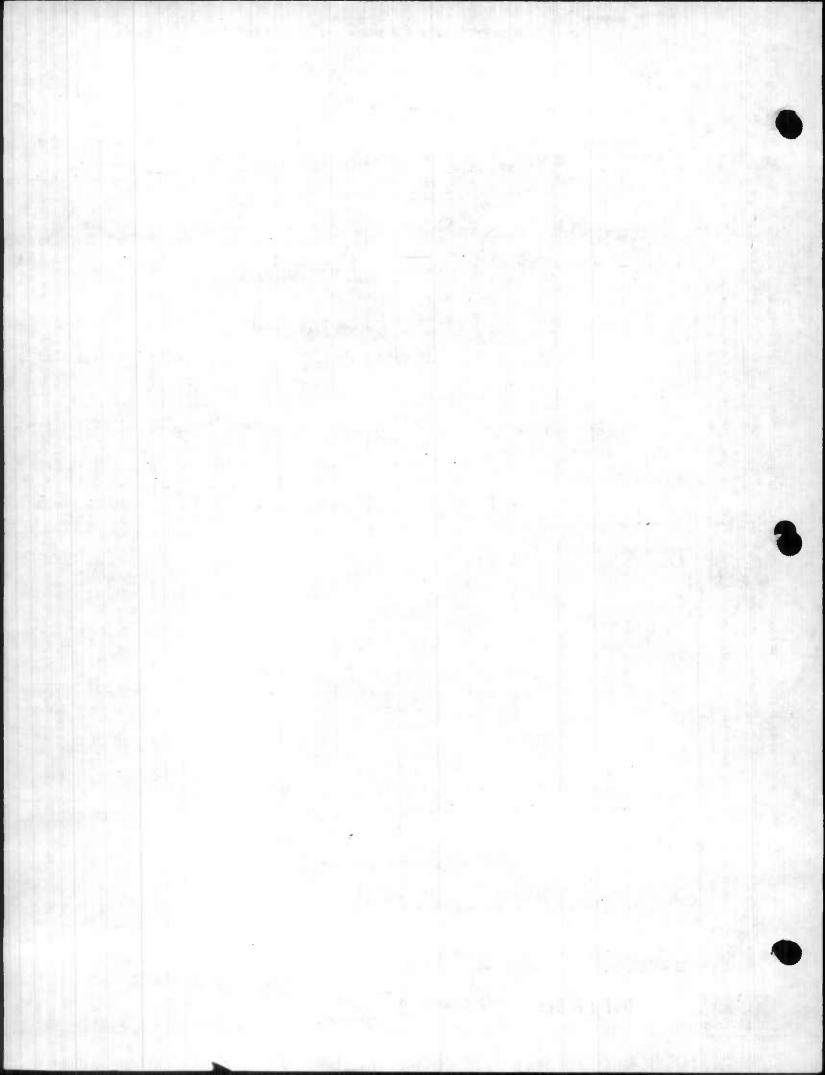
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: 7 PER F.H. G788 10-20-00 WR. Amended Item: 10e,8 perFHG788 101/8/2000 EW Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death Chapman Year Month **Physician** 6:32 pm Geraldine 2000 Oct. /Medical 4e Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Iniversity of Maryland Medical Center Saltimore Baltimore 7. Aga (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. 8. Deta of Birth Months Days Hours Min. (Month, Dey, Year) 1921 Birthplaca (Stata or Foreign Country) 5. Sociel Security Number 6. Sex **Funeral** 215-14-7812 Months Days 10M AF 88 79 Yrs. Director Usual Residence of Decedant 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Yes 2□No BALTIMORE NA WB Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? finer must be n 1004 U S A 14. Race - American Indian, Bleck, Whita, atc. IW. CONWAN 21201 Funeral . Was Decedant Ev Armed Forcas? 1 Yas 2 No If Yas, Giva Year or Detes: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) Ever in U.S. 11. Maritai Status than "natural", or lient the Medical Examiner 1 Nevar Married 2 Married 1 Yas 2 YNo Baltimore, Maryland 21215-0036 Specify: by 3 Nidowed 4 Divorced Black Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales depson NA EWERCH 1044 17. Fether's Nema (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Pages 1 and 2 should be fit treent of Health and Mental H tant. If Item 27 is marked off jury or other traumatic even 88 20 NONNIE Damvel 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Batto 4d. 21215 Gwendolyn 20a. Mathod, of Disposition Edgewood Rd. Apt. 135 3909 20b. Piace of Disposition (Name of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata Bural 2 Cramation 3 Ramoval from Steta butus Men Yark 101 21. Signature of Funaral Service Licens 22. Nama and Address of Facility SWF, FROG TUNGER Home ! march majon Ave. 4300 Wabash BaHo. 21215 0 Entar the disease, or complications that caused the deeth. Do not entar tha mode of dying, such es cardiac or respiratory arrast, or heart tailure. List only one cause on each line. Approximata Intervai Between Onset and Deeth **Physician** Immediata Cause (Finel diseasa or condition rasulting in death) /Medical da **Examiner** to (or as a consequence of): Examir Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disaase or injury that initieted evants Dua to (or as a consequence of): physician a s the burial-Division of Vital Records, P.O. Box 68760, **Physician/Medical** thet initieted evants rasulting in death) Last Due to (or as e consequença of): 4 990 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No signed by the detact 3 Probably 4 Unknown þ 24b. Were autopsy findings eveilabla prior to completion of causa of death? 24a. Was an autopsy performed? Completed ats ha 1 Yas 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to madical axaminar? Be 26. Place of Death (Check only one) Hospital: 1 Yas 2 No Othar: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 2 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: Hospital or Attending 5 Pending investigation Natural 2 Accident 1 ☐ Yas 2 ☐ No 3 Suicida 6 Could not be datamined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Piace of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 T Homicide To the Hospital

Agitin 24 hours a

To the Funeral
Completely filled Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Certifier edical 29d. Data signed (Month, Day, Year) 29c. Licanse number 29b. Signature and title of certifias 4678 -11-00 30. Nama and address of passer, who completed causa of death (Itam 23a) (Type, Print) 22 S. Greene St. Baltimore, MD 21201 Barry J Mark 32. Registrer's Signature 31. Date filed OCT 21. 6 2000 State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32494 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Ben V 2000 Catherine 1600 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Glen Burnie Vorh Hrunde +0501Ta 5. Sociel Security Number 215-16-1330 If Under 1 Y Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) 6 Say Days Months 1□ M 2♥ F Yrs. Aug. Mary land Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland 1 Yes 2X No Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4702 Henshaw Lane 21122 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3XDWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4or 5+) 8 Cashier Retail Grocery 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Mathew Muller Christina Kauten 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frederick Cox (son) 300 Kramer Rd., Pasadena, MD. 21122 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Oct. 14 1 Burial 2 Cremation 3 Removel from State Glen Haven Cemetery 4 Donation 5 Other (Specify) 2000 Glen Burnie, Maryland 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 MOuntain Rd., Pasadena, MD. 21122 24 not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Pen1. Enter the disease, or complications that caused the death shock, or heert feilure. List only one cause on each line. NTRACEREBRAL 1-YEMORRHAGE Immediate Cause (Final disease or condition resulting in deeth) MINUTES Due to (or es e consequence of): PERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last BETES (Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1) Inpatient 2 ER/Outpatient 3 DOA

Examiner physician and s the burial-trans P.O. Box 68760. 2

Physician/Medical Examiner

Be Completed by

Certification: To

Medicai

State Registrar

Physician

/Medical

Physician

/Medical

Examiner

Director

Funeral

Completed by

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-1 show eny injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records. or Attending Physician: after death. To the Hospital of within 24 hours at To the Funerel D

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide 29e. Certifier

5 Pending investigation

6 Could not be

28a. Date of Injury (Month, Dey Year)

1 ☐ Yes 2 ☐ No 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and fit

29c. License number

HOSP MAL DRIVE GLEN BURNIE, MARYLAND 30 Name and eddress of person who completed cause of death (Item 23e) (Type, Print) ENJAMIN MALKIEI

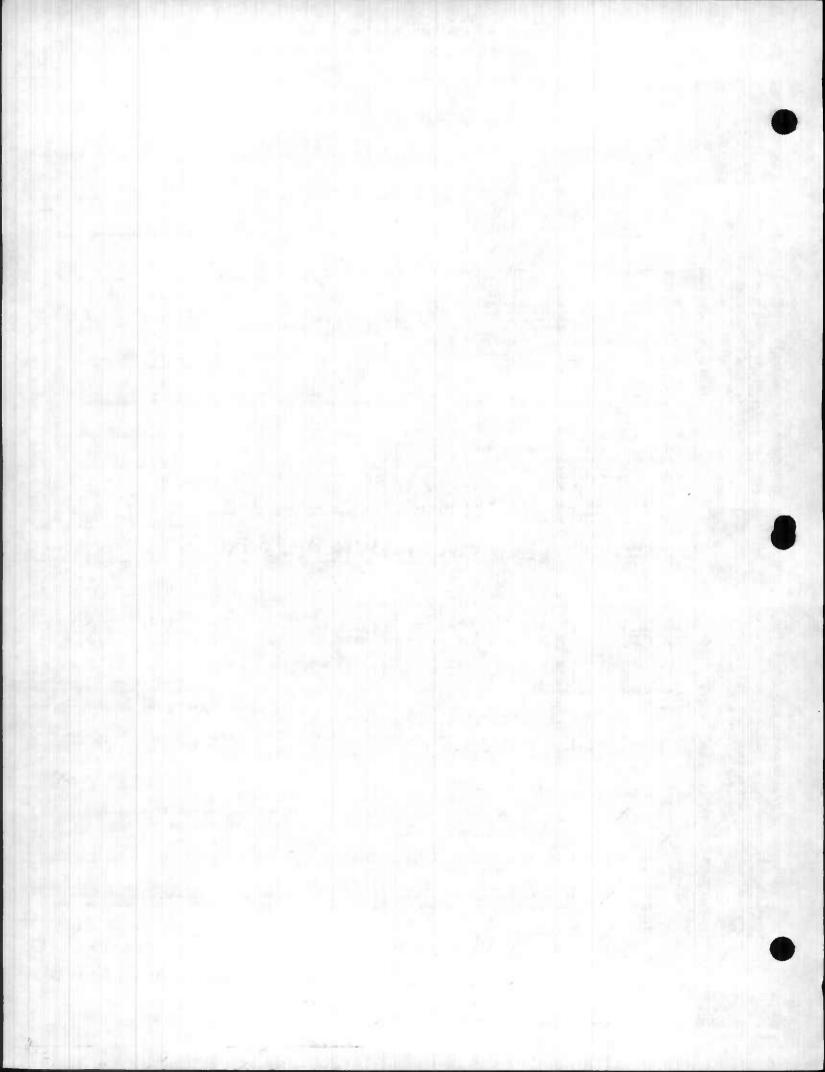
31. Date filed (Month, Dey, Year)

32. Registrar's Signature OCT 1 6 2000

DHMH 16 Rev 6/95

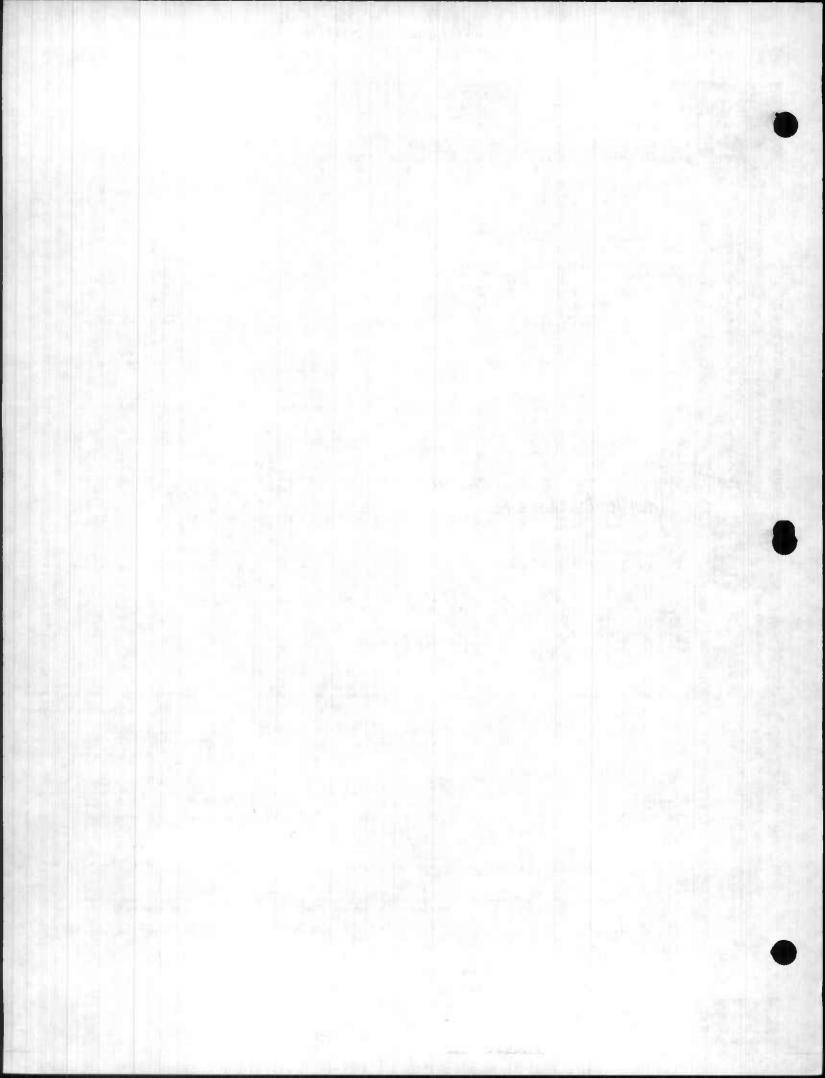
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29d. Date signed (Month, Dey, Year)

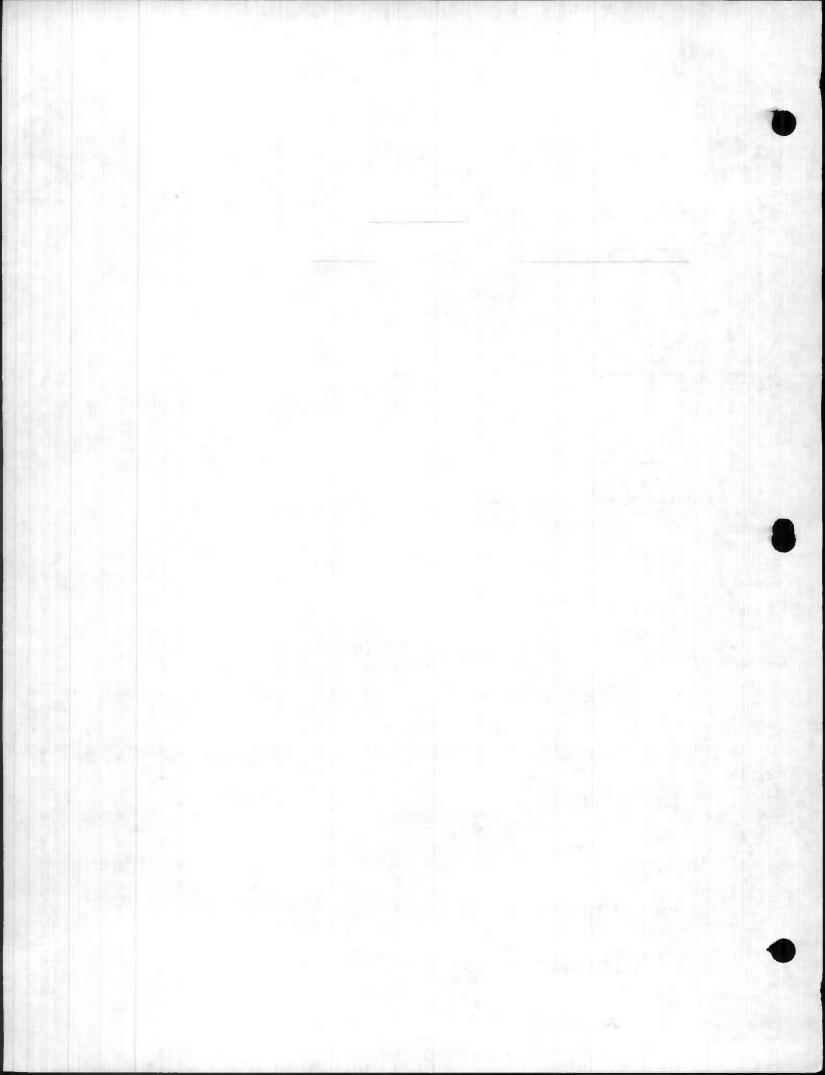


			Certificate	of Death	2. Date of Dea	Reg. No.		3. Time of Deeth			
Physician	1. Decedent's Name (First, Middle, Last,				a Month	Day	Year				
/Medical	Patricia H. Duncar 4a Facility Name (If not institution, give			4b. City, Town, or Lo	OCTOBER	- 12 20 4c. County		9:50 A.M			
Examiner	FRANKLIN SQUARE	11	NTER	ROSEDAL		-	LTIMO	PF			
Funeval	5. Social Security Number 6. Sec		/ear If Under 24 Hrs.	8. Date of Birtl (Month, Da)			ce (State or Foreig				
Funeral Director		OM 2⊠F 61	Yrs. Months D	Days Hours Min.	May 28		Country Mary L				
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the Man 28a-f ah notthed rector	Maryland Baltimore	9					1 ☐ Yes 2 ☑ N				
th with the Ma 23s or 28s-fs 23s or 28s-fs 3s or 28s-fs	8 Mingo Lane		10f. Zip Co	21221		10g. Cifizen of V USA	Vhat Country	y?			
72 hours after death vinetural, or frome 234	11. Marital Status	12. Was Decedent Ever in U,: Armed Forces?	S. 13. Was Deceden	t of Hispanic Origin? (Spe Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Raci	e - Americar				
by by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🗵			Specify					
t, or Moses E.	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Decedent's Usual C	Occupation done during most of worki	na	16b. Kind of Bu	siness/Indu	stry			
	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)		done during most of working tretired)		Constan					
Col	17. Father's Name (First, Middle, Last)	eeper	/First Middle	Constru		1					
To Be Comp	James Hutson			Mary Mas			6)				
traumetic	19a. Intormant's Neme/Relationship (T)	(pe, Print)	19b. Mailing Address (S	Street and Number or Plura	I Route Numbe	or, City or Town,	State, Zip C	Code)			
T #	Robert Duncan (Hus	sband)	8 Mingo La	ne Baltimor	e, Md.	21221					
y or other	20a. Method of Disposition 12 Burial 2 Cremation 3 F	Car	aca of Disposition (Name emetery, crematory or other dens Of Fait	of or place) th Cem. 10/1	Date 6/2000	20c. Location - Baltim					
any injury or once.	21. Signalurer of Funeral Service Licenses Mo 1091 22. Name and Address of Facility Bruzdzinski Funeral Home P.A.										
Department Important: I any Injury o	23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, approximate interval Between										
ysician Medical caminer	Immediate Cause (Finel disease or condition resulting in death)	ne ceuse on each line. LIVER FA					1	nterval Between Onset and Death			
ALL PERSON	Todaming in country	4.4	as a consequence ot):								
in and hal-transit Examiner		METASTI		IVER							
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should						an autopsy rmed?	avai	e autopsy findings lable prior to pletion ot cause eath?			
page 2					101	res 2 No		Yes 2□ No			
Be C	25. Was case reterred to medical			26. Place of Deatl	1		1	100 2010			
- = O	everniner?	lospitel:	ER/Outpatient 3 DOA	Other: 4 Nursing Ho			er (Specify)				
	27. Manner of Death 1.⊠Naturel 5 ☐ Pending 2 ☐ Accident Investigation	28e. Date of Injury (Month, Day Year)	28b. Time of Injury M	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe I	now Injury occur	red				
al Director: After to led in by the funeral Certification:	3 Suicide 6 Could not be determined	ffice	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
within 24 hours are to the Funeral Directory ompletely filled in by Medical Certif	(Check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat									
o the lo	29b. Signature and title of certifier	and manner stated.	29c. l	icense number		29d. Date signe	d (Month, D	ay, Year)			
Co	12 Chil	L1, b.		191825		10112	IAS	7			
-/ (/	D 191825 10/12/00										
5	30. Neme and address of person who co	ompleted cause of death (Item	23a) (Type, Print)				(
5	30. Name and address of person who con RITA MATHUR, MD		23a) (Type, Print) LIN SQUARE	DRIVE, BAL	TIMORE	, MD	21237	7			

DHMH 16 Rev 6/95



	10c,e per fh G788 10/17/State of Mms#10c,e,f perFHG788 10/16/2000 Ex		ertificate of	Death	2. Date of De	Reg. No.	0 32496 3. Time of Death			
Physician /Medical	ROSE MARIE DRABISH				Month Oct.	Day 4,2000	2:30AM			
Examiner	4a Facility Nama (If not Institution, give street and number,				r Location of Deat		of Death			
	Ma Maison 9404 Belair Rd 5. Social Security Number 6. Sex 7. A	ge (fn yrs. last birthde)		Notting			imore			
Funeral Director	236-18-5391 1DM 27F	87 Yrs.	Months Days	Hours Mi	8. Date of Bir (Month, De 10/8/	1912	9. Birthplace (State or Foreign Country) Canton. Ohio			
2 .	Usual Rasidence of Decedent 10e. State 10b. County	10c. City, Town or I	ocation N	- + + ! h			10d. Inside City Limits			
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or 28a-1 s be notified	10e. Street and Number Ma Maison	KINGSVI	10f. Zip Code			10g. Citizen of W	/hat Country?			
	Mia Madison 9404 Belair RD 6 Blue Stone Court		21236 2101			IISA				
her do	11. Marital Status 1 Never Married 2 Married 1 Was Decedent Armed Forces 1 Yes 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Yes 2 Married 1 Yes 2 Married 1 Yes 2 Married 1 Yes 2 Married 1 Yes 2 Married 1 Yes 2 Married 1 Yes 2 Married 1 Yes 2 Married	Ever in U,S. 13	Was Decedent of If Yas, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? pan, Mexican, Pue	(Specify Yes or No erto Ricen, etc.)	Specify	e - Americen Indian, k, White, etc. : white			
72 hou	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occu re kind of work done	pation	ordkina	16b. Kind of Bu				
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d 2 should be filed within 72 hours at 0 and Mental Hygiene. 7 is marched other than "natural", or fraumatic event, the Medical Exam To Be Completed by 3	19a. Informant's Name/Relationship (Type, Print)		iling Address (Stree							
E 20 P E	Linda Mattio (daughter 20a. Method of Disposition) 6 B		ne Cour	t Kings		MD 21087 City or Town, State			
nemit. Pages 1. Separtment of He apportant: If item iny injury or oth	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cr	ematory or other ple				river to the second			
mit. P partime portan / Injur	21. Signature of Financial Service Licensee		Creamto 22. Name and Addr	ess of Facility	10/7/00		e, Maryland			
84488	23a. Part1. Enter the disease, or complications that cause	uneral		MD 21087						
Physician /Medical Examiner	snock, or near tailure. List only one ceuse on each	the death. Do not eline. Toke Due to (or as a cons	Pict.	ing, such as cerd	ac or respiratory t	irrest,	Approximate friends Between Onset and Death			
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leath certificate be executed a strending physician and for use as the burial-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
Seath certification of for use a	Doe'd Other simificant conditions contributing to dooth	22h Did	Did tobacco use contribute to the cause of death							
requires that the death certifical rees signed by the attending phy hould be detected for use as the reed by Physician/Medi	Partit. Other significant condutions contributing to beautiful	ntributing to death but not resulting in the underlying ceuse given in Part I.					3 Probably 4 Tonknow			
2 2 5					24a. Was perf	s an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?			
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Physician: The this certificate ral director, page Co.: To Be Co.	25. Was cese referred to medicel axaminar?			thor	eath (Check only					
Physic or this o eral dire	27. Manner of Death 28a. Date of Inj	ury 28b. Time	of 28c. Inju	4 LI Nursing	Home 5 Thes	how injury occurs				
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tal or Attending P is after death. al Director: After ted in by the funers Certification:	3 ☐ Sulcida 6 ☐ Could not be determined 28e. Place of In building, e		28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)							
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To the within 2 To the comple	29b. Signatura and fitla of certifiar Samuel C. Durnoy	~>>		sa number 7040		29d. Date signed (0 / 4/	(Month, Day, Year)			
	30. Name and address of person who completed ceuse of Samuel C. Dunso	MB 49	24 Camp	hell Blue	1 Suite 2	or Balt	100 Himore M1 21236			
State	31. Date filed (Month, Dey, Year) 32. Regist	rar's Signature	19 1							



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 15, **Physician** Henry Earnest DiNicola, Jr. October 2000 3:03 pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Franklin Square Hospital Center Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 26, 1931 Pennsylvania 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 113 M 2□ F 211-20-6239 69 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23s or 28s-f show th and Mantal Hygiene. ?7 is marked other than "natural", or freme 23s or 28s-1 ahov traumetic event, in Madical Examina must be notified at Maryland Baltimore Essex 1 Yes 2010 Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 323 Southeastern Terrace 21221 U.S.A. Funeral death v 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Stetus 1 XYes 2 No If Yes, Give 1951 filed within 72 hours aftar 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: þ If Yes, Give Year or Dates: 1954 White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Insurance Company Sales Agent Il Hygie 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy
Important: If them 27 is marked oth
any injury or other traumatic event Antionetta Gatta Henry DiNicola 19a. Intorment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 323 Southeastern Terrace, Essex, Maryland 21221 Josephine R. DiNicola (Wife) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 10/18/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A. 21_Signature of Furural Service-Ligense 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical tmmediate Ceuse (Final da disease or condition resulting in death) Examiner to (or # a consequence ot) Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury been signed by the ettending physician and should be deteched for use as the burial-tran Due to (or as a consequence of): The law requires that the death certificete be execu Box 68760. thet initiated events resulting in death) Last Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown pertension Be Completed by 24b. Were autopsy tindings eveilable prior to completion of cause of death? 24a. Was an autopsy performed' has 1 Yes 2 No 1 Yes 2 No After this certificate Physician: eral Director: After this certificalled in by the funerel director, 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28d. Describe how injury occurred Injury et Work? Attending 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 ☐ Accident 28t. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) or A eftar 4 Homicide To the Hospital within 24 hours a To the Funeral Completely lilled Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29a. Certifier 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifie 10/16 D5237 SHIVANAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR- SAVITHA male 121 Baltimo Avenue 31. Date tiled (Mg 32. Registrar's Signatura

Registrar DHMH 16 Rev 6/95

State

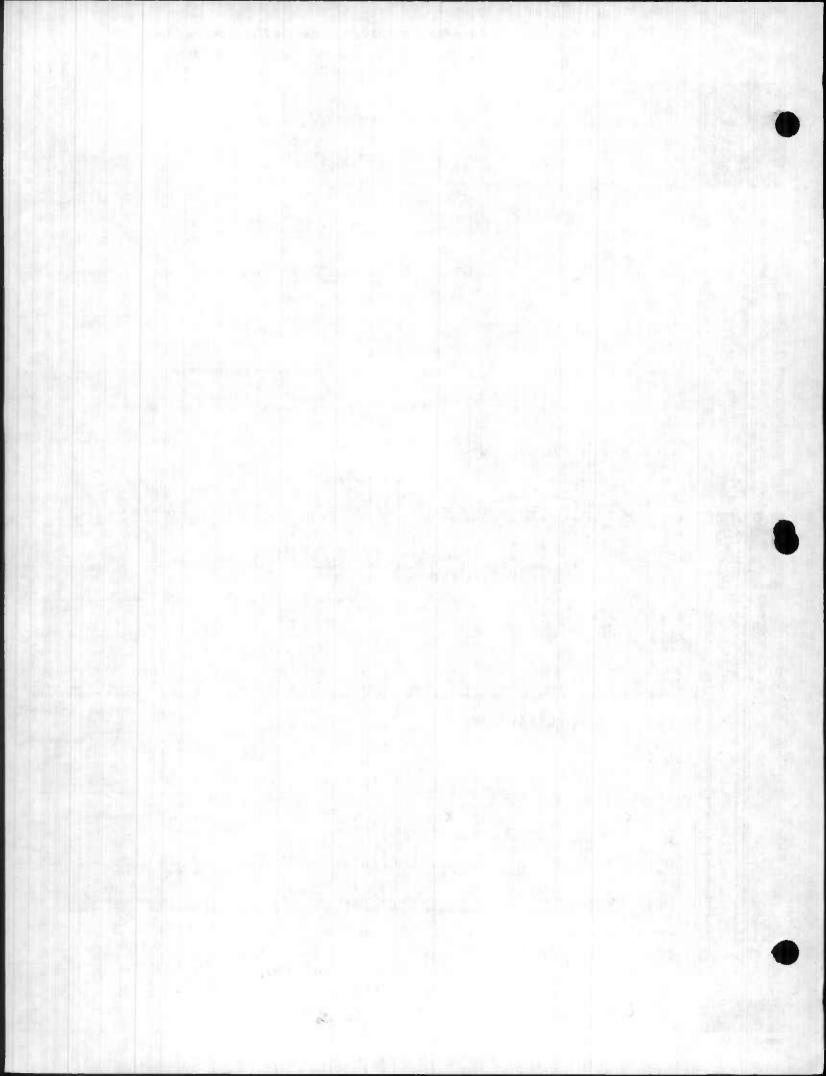
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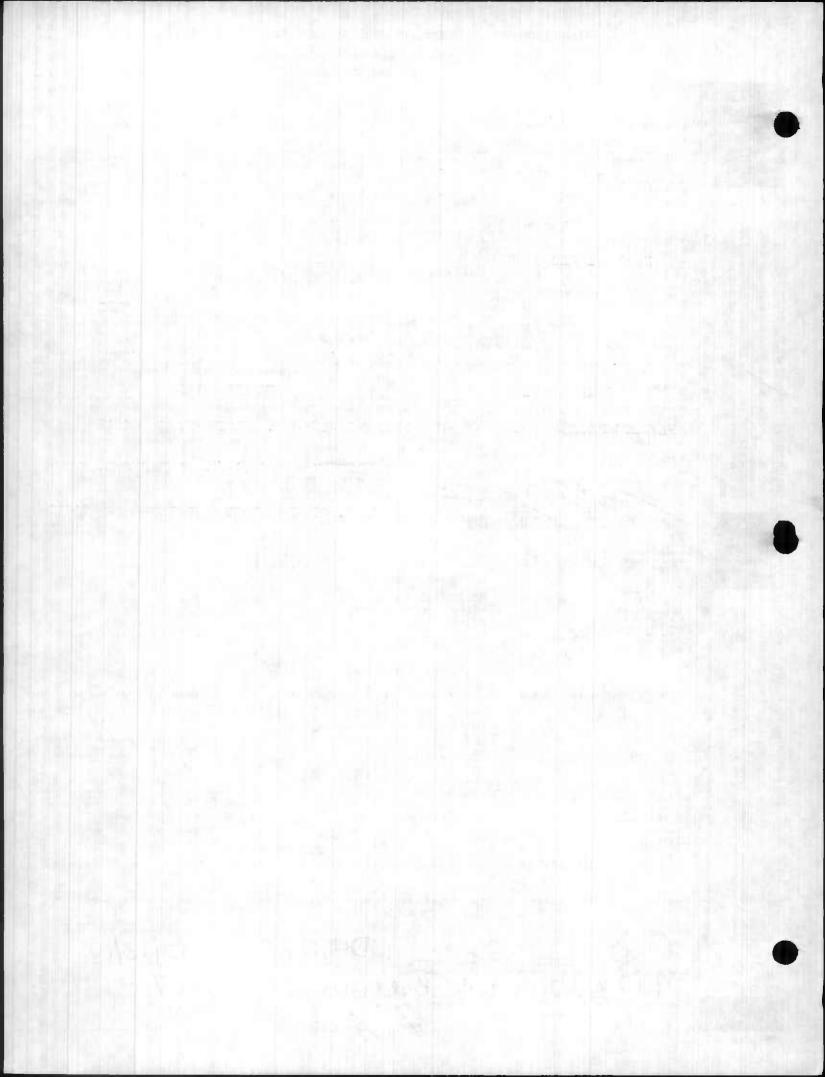
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State of Maryland / Department of Health and Mental Hygiene

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Special part Spec								4b. City, Tow	m, or Location of Do	eath 4c. County	of Death			
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COPD 21. Signature of Funeral Superest Logardian 22. Name and Address of Facility WYLTE FUNERAL HOME PART 10/14/00 LANDSDOWNE, MD 22. Name and Address of Facility WYLTE FUNERAL HOME PART 10/14/00 LANDSDOWNE, MD 22. Name and Address of Facility WYLTE FUNERAL HOME PART 10/14/00 LANDSDOWNE, MD 22. Name and Address of Facility WYLTE FUNERAL HOME PART 10/14/00 LANDSDOWNE, MD 10/14/00 LAND	re,	A Head		20a. Mathod of Disposition		20b. Place o	f Disposition (Nama of				- City or To	own, Stata		
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1 922W Wan Ave Bultimore, MO 21217		B		30 Name and address of nerson who	completed cause of 4	eath (Itam 22c)					1	~		
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 13. (First Middle Legib)

1. Decedent's Nama (First, Middla, Last) 2. Data of Death October **Physician** FISHER WILLIS 12:45AM 13,2000 /Medical 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Rehabilatation and Extended Care N/A 7. Aga (In yrs. last birthday) | If Undar 1 Yaar | If Undar 24 Hrs. | Months | Days | Hours | Min. 5. Social Sacurity Number 6. Sax Birthplaca (Stata or Foraign Country) **Funeral** 1 XM 2□ F 80 Days Hours Yrs. Director Virginia the Maryland 10a State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Insida City Limits MD Baltimore Director Baltimore 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 3406 Keston Road 21207 USA permit. Pages 1 and 2 should be filed within 72 hours after death begattment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23, any Injury or other traumetic event, the Medical Evantural must 12. Was Decedant Ever in U.S.
Armed Forcas? 10/16/43 If Yas, specify Cuban, Maxicen, Puarto Rican, atc.)

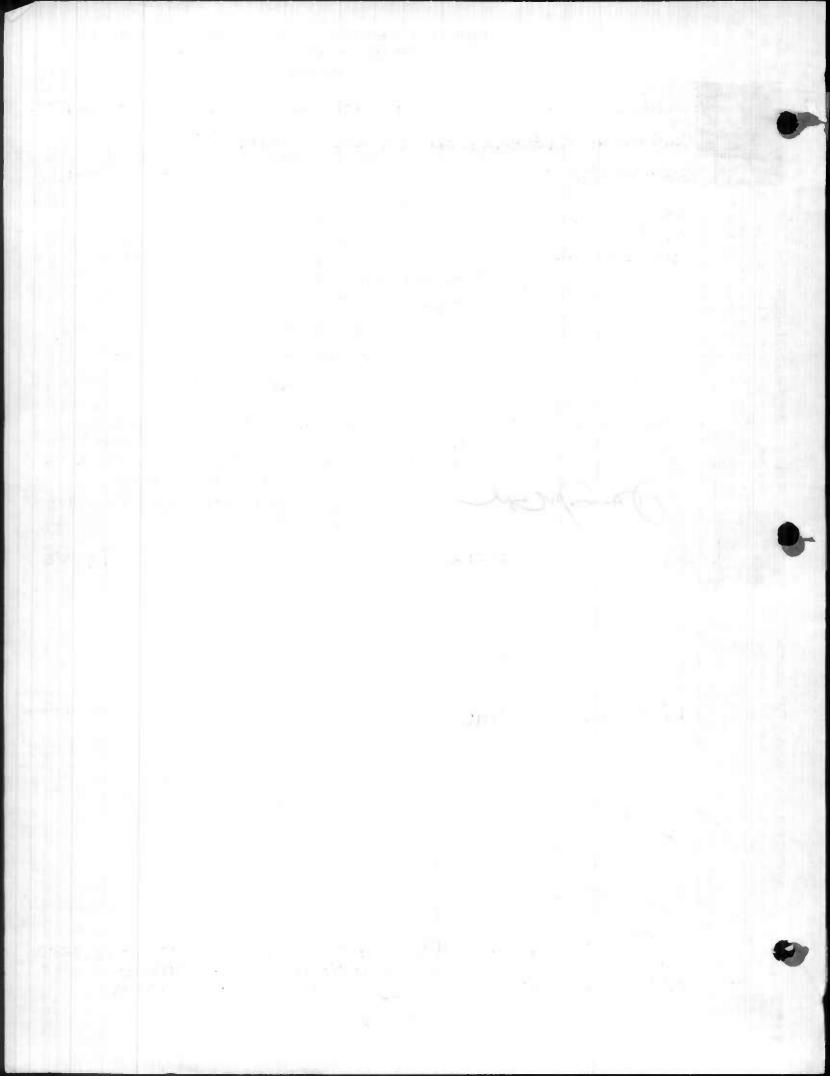
1 Styles 2 No
If Yes, Giva
Yaar or Datas: 04/11/46 1 Yas 2 No Specify: 11. Marital Status 14. Race - Amaricen Indian, Black, Whita, atc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 Black by 3 Widowed 4 Divorcad Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadant's Education 16b. Kind of Businass/Industry (Specify only highast grada completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) 12th Crain Operator Steel 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Sam Fisher Mamie Fisher 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Alberta Fisher (Wife) 3406 Keston Road Baltimore, Maryland 21207 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burlal 2 Cramation 3 Ramoval from Stata Garrison Forest Vet Cem 10/19/00 Owings Mills, MD. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Caple Funeral Service 21. Signature of Funaral Sarvice Licansaa 5502 Winner Avenue Baltimore, Maryland 21215 23a. Part 1. That tha disaasa, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwe **Physician** /Medical Immediata Cause (Final Stroke TYEARS disaasa or condition rasulting in daath) Examiner Dua to (or as a consequance of): Examiner Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Diseasa or Injury that initiated evants rasulting in death) Last pug Dua to (or as a consequance of): physician is the buria Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaquance of): ä attending Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the Mellitus Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 2 24b. Wara autopsy findings availabla prior to complation of ceuse of death? Completed 24a. Was an autopsy performad? page 2 멾 1 Yas 2 10 No 1 ☐ Yes 2 ☐ No Be 25. Was cesa refarred to medical examinar? 26. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 10 1 Inpatiant 2 ER/Outpatient 3 DOA 報 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: Ather 1 Natural 5 Panding Invastigation if or Attending after death. I Director: Att 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be detarmined 3 Sulcida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) B 4 Homicida To the Hospital or within 24 hours at To the Funeral D completely filled is 1 Certifying Physician: To tha best of my knowledge, daath occurred at the tima, data and place, and dua to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and mannar stated. 29a. Certifian Medical (Check only one) 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) D0032548 October 13,2000 person who completed cause of death (Item 23a) (Type, Print) 10 North Greene Street L Colvin Baltimore, Maryland

State Registrar

31. Data filed (MOMM, Day, Yaar)

OCT 1 6 2000

32. Ragistrar's Signatura & Span



State of Maryland / Department of Health and Mental Hygiene 00 32500

	Certificate of Death		Reg. No.	00	32300				
oleion	Decedent's Nama (First, Middle, Last)	2. Data		Year	3. Time of Death				
sician edical	MARGARET ELEANOR WHITELEY FOSTER	OCT	14 2	000	5:00g				
niner		n, or Location of	Death 4c. Coun	ty of Death					
	213 EDGEVALE RD. BALTI		N/	A					
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days Hours	Min. (Mont	of Birth h, Day, Year)	placa (Stata or Foraign ntry)					
	220-46-6637 1 M 244 89 Yrs. Supplemental Sup	03/	01/1911	MAH	RYLAND				
	10a. Stata 10b. County 10c. City, Town or Location			1	10d. Inside City Limits				
ō	MD N/A BALTIMORE				1⊠Yas 2□ No				
Director	10e. Street and Number 10f. Zip Code		10g. Citizen of	What Cour	ntry?				
	213 EDGEVALE RD. 21210		USA						
runeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	n? (Specify Yes		ice - Amari	can Indian,				
2	1 Never Married 2 Married 1 Yas 2 No	Puerto Rican, ato		ack, Whita,	atc.				
	3 Widowed 4 □ Divorced Year or Dates:		Spec	ity: WF	HITE				
Popular	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of	of working	16b. Kind of	Business/In	dustry				
Completed	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired) (Give kind of work done during most of life. DO NOT use retired)	n working							
Co	4YRS ARTIST			rist					
8			iddle, Maiden Suma	me)					
10		SE E.							
	19a. Informant's Name/Relationship (Type, Print) SALLY L. FOSTER (DAUGHTER) 213 EDGEVALE RD.								
		DALIU	20c. Location						
	1 Burial 2 □ Cremation 3 □ Removal from Stata cemetery, crematory or other place)								
	4 □ Donation 5 □ Other (Specify) DRUID RIDGE CEM.	10/17/	2000 PI	KESV1	ILLE, MD.				
	21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility HENRY W. JENN	S SMIX	SONS CO						
	William Claude 4905 YORK RD.								
Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):								
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cau								
		24a.	Was an autopsy performed?	a\	ere autopsy findings vailable prior to				
					ompletion of cause death?				
rector, page 2 should Be Completed			1□ Yas 2 No	11	☐ Yes 2 No				
	25. Was case referred to medical axaminer?	of Death (Check	only one)						
000	Hospital Other	sing Home 5	Residence 6 🗆 O	thar (Speci	(fy)				
the funeral di	27. Manner of Death 1 Natural 5 Pending 28a. Data of Injury (Month, Day Year) 28b. Tima of lnjury 28c. Injury at Work?	28d. Desc	cribe how injury occi	urred					
Caro	2 Accident investigation M 1 Yas 2 No	0							
	3 ☐ Suicide 4 ☐ Hornicide 6 ☐ Could not be determined 28e. Place of Injury - At horna, farm, street, factory, office building, etc. (Specify)		tion (Street and Nun or Town, State)	nber or Run	al Routa Number,				
Certifi									
BICS	29a. Certifier (Check only one) (Check only one) (Check only one)	occurred at tha	o tha cause(s) and r time, data and place	nanner as s , and due t	stated. to the cause(s)				
5	29c. License number		29d. Data sign	ned (Month.	Dav. Year)				
1	Marking 4. Kens, my 037272		October	114	March				
	30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN G. REICH M.D. 601 N. CAROLINE ST.	BALTO.	MD. 21	287.					
	31. Data filed (Month, Day, Year) 32. Registrar's Signatura	2112100	,						
tate trar	OCT 16 2000								
strar	CHELL D 2000 Legans &								

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